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# EYE CARE CRISIS

PARTS I and II  
by Victor H. Krulak

As it appeared in THE PEN, Vol. 2, No. 6, Nov. 15, 1978



V. H. KRULAK

*The editors of THE PEN are grateful to THE COPLEY NEWS SERVICE for releasing publication rights to a two-part newsfeature essay which appeared in newspapers throughout the nation. California journalist V. H. Krulak has done extensive research into the complexity of the current invasion of medicine by non-medical measuring scientists and the effort of medicine to resist intrusion for the sake of the public health. Mr. Krulak's complete analysis, already exposed to millions of Americans, is published in this issue. PEN salutes Copley News Service for an outstanding public service.*

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LIEUTENANT GENERAL VICTOR H. KRULAK, U.S.M.C. (Retired) - General Krulak, a native of Denver, Colorado, now residing in California, was graduated from the U.S. Naval Academy in 1934. Prior to his retirement from the U.S.M.C. in 1968, he served in every quarter of the globe. He has won an impressive array of U.S. and foreign decorations, including the Navy Cross for heroism in World War II.

Upon retirement, General Krulak became Vice President and a Director of Copley Press, Inc., a position he held until 1977.

A member of many local and national civic organizations, he participates in a wide range of community welfare activities. As a journalist, he has written on Asian affairs, international politics, ecology and national defense. He has received national awards for his patriotic writing and speaking and honorary degrees from Loyola University and the University of San Diego.

## EYE CARE CRISIS I

V. H. KRULAK

One American in two wears glasses. 10 million have some sort of vision impairment not correctable by lenses. 31 million take their eye problems to some kind of practitioner every year.

Despite all of this, the average eye sufferer does not know much about the people he expects to treat his ills.

It is unlikely, for instance, that one in a thousand can explain the difference between an oculist, an optometrist, an ophthalmologist and an optician.

"Something to do with eye care," he would probably say, — and that is not enough, considering how precious his eyes are, how complex they are and how sensitive many of their problems are.

By reasonably accepted definitions, an optometrist is a man who examines the human eye to detect focusing errors and fits lenses to correct those errors; an ophthalmologist is a physician — an M.D. and surgeon — who diagnoses what is wrong with your eyes, whether you need glasses, medication or surgery, and then does what is necessary; an oculist is an ophthalmologist — the terms are synonymous; and an optician is a man who makes and fits glasses to your face in accordance with a prescription prepared by someone else.

Put more simply, an optometrist is a limited practitioner; an ophthalmologist — or an oculist — is a physician who specializes in the eye; and an optician is a technician.

These distinctions are important to the person who thinks he needs his glasses changed, or who

has blurred vision, headaches, reading difficulties, or any other problem that may be related to his eyes.

They are important not only to the preservation of his eyesight, but to what the diagnosis and treatment of his problem will cost him. Because eye care — critical as it is — has become big business. And, being big business, the customer — in this case the patient — along with his precious eyes and his pocketbook — all stand to suffer if they do not know what they are buying.

The business issue focuses on the optometrists and the ophthalmologists. The optometrist says that anyone who thinks he has an eye problem should see an optometrist first. The ophthalmologist says this is potentially dangerous and costly, that optometrists are not trained in the essentials of eye problem diagnosis and that anyone who thinks he has eye troubles should see a physician first.

The optometrists have advanced their ideas through an aggressive program of hard sell which, until recently, had generated only uncoordinated resistance on the part of the ophthalmologists. The optometrists' formula is simple — persuade the general public that they are "general practitioners of the eye" and thus the first contact point for an eye ailment and, second, to persuade state legislatures to enact laws which broaden the optometrist's function, requiring anyone seeking eye care under a public medical program to consult an optometrist first.

They are pursuing their plan with aggressiveness and skill. There are 21,000 of them in the United States, organized in a tight American Optometric Society that spends a third of a million dollars a year on public relations. The Society has a staff larger than the American Medical Association. It has powerful lobbying teams in Washington and many State capitals, seeking legal authority to use drugs in their practice and otherwise to broaden their function; and they are making real progress in creating both a state of mind, and a basis in state law—W. Virginia and North Carolina are examples — that sees them as the logical primary eye care resource.

The ophthalmologists oppose this program on purely professional grounds, contending that an optometrist, not being trained as a physician, cannot diagnose disease, or prescribe, treat or cure disease if detected, and thus should not be the portal through which everyone with eye problems should pass.

So, the individual, whose aim is simply to have his eyes put right quickly, efficiently and economically, and the health plan, that wants the job done at minimal cost, can be caught in the middle.

There seems to be little question that a good optometrist can test your eyes and prescribe glasses

to correct simple focusing errors. He will probably do the elementary job well, and the cost will be about the same as if the basic examination were performed by an M.D. eye specialist.

The real problem arises in the many cases where the blurred vision, squinting, headache or reduced ability to see is the product of something more than a simple congenital defect or the slow deterioration due to age.

These cases are by no means rare, nor can they be anticipated in advance. The eye complaint might stem from brain problems, kidney disorder, high blood pressure, diabetes, thyroid trouble, a tumor or any of a dozen other diseases recognizable only to a trained doctor who comprehends the whole body and can detect disease through the patient's eyes. There are, for example, probably 10 million diabetics today who are candidates for blinding ailments alone — and don't know it.

If this is the sort of complaint the patient brings, money spent at an optometrist's office is not going to buy what he really needs, because that kind of diagnosis and the treatment that must follow are outside the optometrist's field.

He is trained primarily as a technologist. The schools of optometry — of which there are thirteen in the United States — are, except in one case, not related directly to any medical institution. Unlike medical students who are obliged to see hundreds of sick people of all types during their educational life, the optometrist's education is largely technical in nature and remote from any medical setting. He requires a high school diploma prior to his formal college education, which extends to two years of college and about four years of optometric school. And those optometrists who are older than 50 are likely to have had even less formal education.

This stands in considerable contrast to the eye doctor whose education as an ophthalmologist requires about fifteen years, including three years as a hospital resident in his specialty.

The ophthalmologists, in defending their professional status, have begun a belated counter-attack, on the ground that sheer lack of medical knowledge — as well as lack of practical medical experience — on the part of the optometrists has sometimes resulted in physical tragedy. Documented cases of optometrists failing to detect serious disease, glaucoma or tumor, with resultant grave effects, are beginning to come to the surface, leaving no doubt that the professional issue between the groups has definitely moved to a higher level of conflict. ●

## EYE CARE CRISIS II

V. H. KRULAK

Emotions sometimes run quite high in this competition for the opportunity to look after John Q. Public's eye ills. Optometrists charge that the physician eye specialists are "attempting to smother us under the hand of medical tradition" and "We are the dentist of the eye, and ought to be recognized as such."

The dean of a large school of optometry declares that ophthalmologists are overtrained for the task of examining eyes, and that the solution is "a national health plan where the Federal Government refuses to pay practitioners high fees for doing work for which they are overtrained".

The ophthalmologists, for their part, declare "The optometrists are trying to substitute legislation for education" and "We have seen many cases of severe eye damage caused by the improper use of drugs by limited practitioners as well as numerous cases of disease overlooked by optometrists."

And, in contrast with the optometrists' view, the dean of a large medical school says, "Optometrists are undertrained for what they would like to do (ophthalmic care)," and that "The optimal solution is for optometrists to do all or most refractions in a group practice setting under the supervision of an ophthalmologist."

Optimal or not, this solution is not likely to come to pass, because the two groups are poles apart. Only public awareness of the facts is going to bring their functions into perspective.

In this connection the ophthalmologist has much the stronger case. There is much, for example, to validate their charge that the optometrist is bemused by efforts to generate legislation. The national optometric organization has created a "Legislative Manual" that minces no words. Some of its topic headings "On Organizing to Lobby", "On Cementing Ties with Legislators", "On Soliciting Support for a Bill" exhibit a no-holds-barred approach to carving out a position in society for the optometrist through legislation.

One of the most intensive of the current lobbying efforts relates to the desire of optometrists to use therapeutic drugs in their diagnostic work. This campaign has aroused widespread opposition among M.D.s of all types, who declare the optometrist to be incapable of handling some of the drugs involved, pointing out the many hazardous reactions that can arise from improper use and administration of drugs.

A leading ophthalmologist, Dr. David W. Parke, President of the Connecticut Society of Eye Physicians, laid the case out in hard terms, noting



that optometrists are not presumed "by background, training, or experience to have the capability to diagnose medically related eye problems or eye disease", and noting that the use of drugs by optometrists "could be extremely dangerous".

Despite this kind of opposition, optometrists have been successful in getting some limited legislative blessing upon their use of drugs.

Not all optometrists are happy with this development. One, Robert Greenburg of Reston, Virginia, recently told the Virginia Optometric Association, "Implicit in the decision (for optometrists to use drugs) is a major change in the scope and definition of optometric practice and the very real danger of re-defining ourselves right out of practice."

Another, David Surkin of Berwyn, Pa., wrote *Optometric Weekly*, "Dallying with military, health and drug bills — is about as insane as painting and improving your house as it burns down."

The bottom line in the conflict between the optometrists and the M.D. is, of course, in quality of service. In that regard the ophthalmologist — the eye specialist, physician, has all the edge — depth of education, breadth of training, diagnostic experience with the sick. If there is nothing wrong with the patient other than the need for simple corrective lenses then an optometrist could, indeed, do the job. But there is no certain way of knowing whether there is something more serious at the root of the patient's eye complaint — and the ophthalmologist — not the optometrist — is the one who can find out for sure.

Next to the bottom line is the cost to the patient — or cost to his medical plan.

In seeking to acquire some data on costs, seven ophthalmologists and seven optometrists were asked the same question: "How much will you charge to give me a complete eye examination, tell me if I need glasses and prescribe them if I do?"

The average price for the examination quoted by each group was about \$36.

Each individual was then asked a second question: "When you examine my eyes, will you be able to give me a medical opinion as to whether I have disease symptoms for such things as diabetes or kidney trouble or thyroid trouble and, if so, can you tell me what to do about it?"

All seven ophthalmologists replied affirmatively — that they could give such an opinion, and prescribe treatment if necessary.

One optometrist said yes, that he could do it; one said it was not possible to appraise such things via the eye; four said frankly that their eye examination did not cover such things; and the last

one evaded the question, declining to answer.

Two of each group were actually told to proceed with the examination. In the case of the two ophthalmologists, the procedures were similar — refraction, various tests for such things as depth of perception and glaucoma, and an inspection of the interior of the eye to give basis for an opinion on the existence or absence of other disease (diabetes, thyroid, etc.).

They each produced a prescription for glasses — the two prescriptions were identical — based on their conclusion that glasses were needed for reading only.

The two optometrists conducted what seemed to be a more limited examination, and both concluded that glasses were needed. One recommended bifocals, for reading and distant vision; the other recommended contact lenses. Both offered to sell the lenses (and frames) required.

When asked for their prescription the optometrists prepared them, and it was noted that they differed considerably — one calling for reading glasses only, and with a different correction than prescribed by the other optometrist.

This experience, while revealing in terms of what the patient got — or did not get — for his money, is less dramatic than a similar survey made by a national newspaper earlier this year. It disclosed that twelve optometrists out of seventeen consulted by a reporter, who had been certified by an eye specialist as having perfect vision, declared that he needed glasses. He was variously advised, according to the report, that he was nearsighted, that he was far-sighted, that he needed glasses for reading only, or that he needed them all the time. And the price varied between \$5.00 and \$85.00.

Only five of the seventeen concluded that the reporter did not need glasses. One of the seventeen was outspoken, declaring that anyone saying the man needed glasses, was "just trying to make a quick buck."

There is little likelihood that the two groups will come together on their own, and there is even less likelihood that any amount of Federal or State law or regulation designed to bring them together will do anything more than add to bureaucracy and cost, without increasing the assurance of quality eye care.

In the end the solution will have to lie with the patient. When he learns the seriousness of the stakes involved. When he knows what he needs and deserves in the way of diagnosis and economy, and when he demands it, the issue will fall into reasonable perspective. ●

### The Scope Of The Copley News Service

*Copley News Service (CNS) is the world's largest supplemental news agency offering in-depth coverage and diversified features to more than two thousand newspapers, dailies and weeklies, throughout the U.S. and abroad.*

*CNS maintains bureaus in the capital cities of those states where Copley newspapers are published — Sacramento, California and Springfield, Illinois as well as in Washington, D.C. and Los Angeles, California.*

*In addition, scores of correspondents throughout the world keep their fingers on the pulse of the international news scene to bring to editors the "why" behind significant news developments. The Copley bureau was established in 1944 and the news service was created in 1955.*

# PEN...

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# COMMITTEE REPORT

## HOUSE

FURTHER: JUDICIARY

1-24-79

Date: 3/21/80

Mr. Speaker:

The Committee on HESS has had HB 79

"An Act relating to the practice of optometry."

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

- do pass  do not pass
- do pass with attached amendments(s)
- replace with CS for HB 79  same title  
 new title
- and recommends \_\_\_\_\_
- AND attaches a "Letter of Intent"  New Fiscal Note
- reports it back without <sup>and</sup> recommendation
- referred to the \_\_\_\_\_ Committee

MEMBERS SIGNING  
DO PASS

B. Hill  
~~\_\_\_\_\_~~  
Joye Hanson  
T. Buchholdt  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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MEMBERS HAVING  
OTHER RECOMMENDATIONS:

Shelton No rec  
R. Dukes No Rec  
Mike Beine - do not pass  
 \_\_\_\_\_  
 \_\_\_\_\_

T. Buchholdt  
CHAIRMAN

*Copies to members  
HB 79*

JUNEAU MEDICAL CENTER

R.R. 3, BOX 3051

JUNEAU, ALASKA 99801

PRACTICE LIMITED TO THE EYE

ROBERT N. PAGE, JR., M.D.

January 31, 1980

Representative Charles H. Parr  
Pouch V  
Juneau, Alaska 99811

Dear Representative Parr:

You will be considering HB 79 and Senate Bill 75. If passed, these bills would permit Optometry, a non-medical measuring science, the use of potentially dangerous prescription drugs. These drugs would be used for the diagnosis of disease, for the determination of the absence of disease and, in certain cases, in the treatment of disease.

Most of your constituents and Americans in general are unaware of the fact that Optometry is in no way a medical science. Optometry's national advertising ("Your Family Doctor of Optometry"), as well as their lobbying before this and other state legislatures, has been deceptive.

If this legislature grants the privilege of practicing medicine to this non-medical group by legislative fiat rather than by educational achievement, it will further compound this public deception.

There is amassed ample irrefutable evidence that this policy has caused great harm, unnecessary suffering, loss of vision and economic loss in the form of recovered damages. I enclose examples of such evidence.

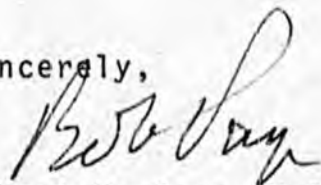
I know you are burdened by many more important issues; few, however, have the potential of impacting as heavily and adversely on Alaskans' public safety from a health point of view.

Please consider these points and call on me at any time if I can help.

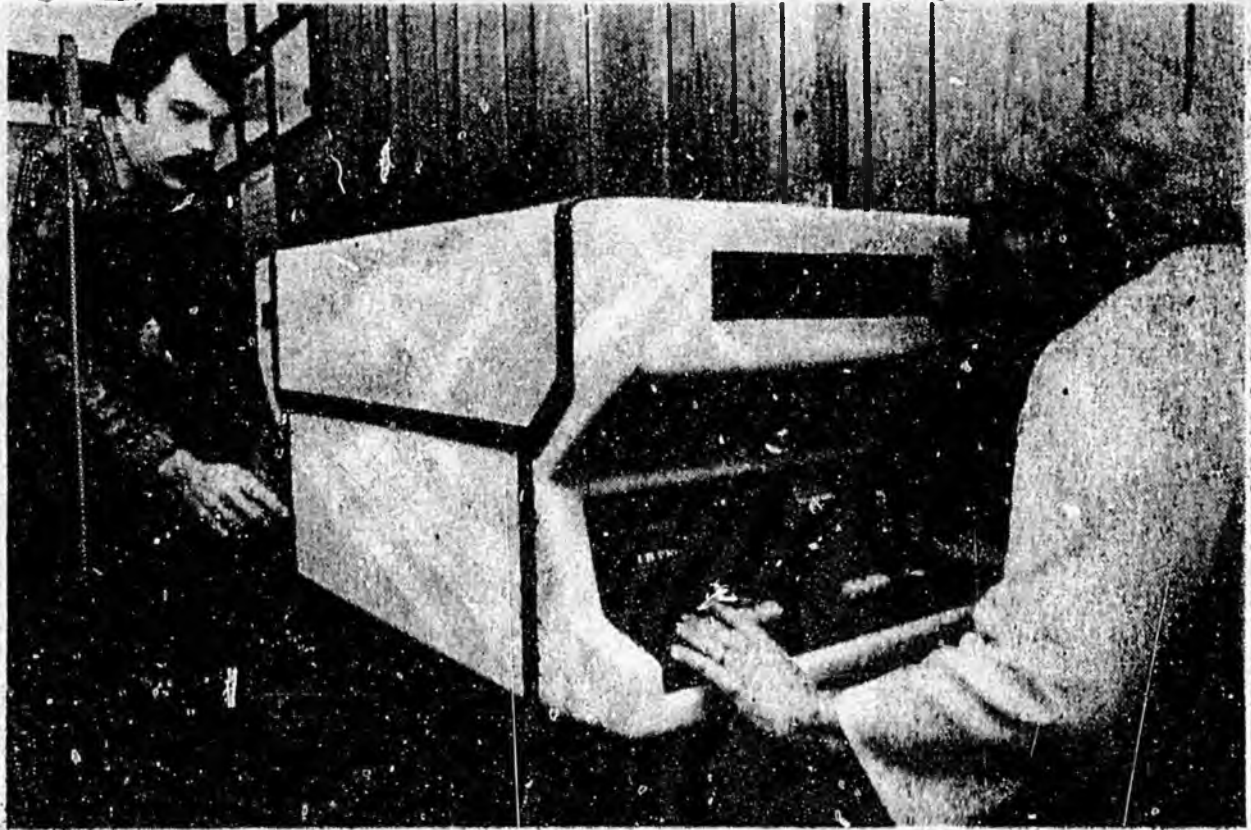
*Charlie, Please  
Many Thanks for  
Past Support  
R.P.*

Enclosures

Sincerely,



Robert N. Page, M.D.



### MACHINE SIMPLIFIES EYE TESTS

With this space-age computerized device, technicians can have a patient's glasses prescription in hand in about a minute and a half. However, traditional procedures are still followed for much of the examination. At left,

Dr. Bill Faulkner adjusts controls for a seated patient. At the other end of the machine optometric technician Carolyn Hazel prepares to take the reading, printed out on a small slip of paper.

## Computer Gadget Comes To Town To Help Determine Eyeglass Needs

An automatic vision refractor, born of space-age technology, now is in service in Anchorage.

The computerized machine takes just 90 seconds to establish the correct prescription for eyeglasses. The patient needs no eye drops nor does he need to make decisions as to which correction helps him to see better.

Even if the patient can't speak, the machine will read his eyes and pick out the proper correction, at least to a point.

Installed at the Anchorage Eye Clinic, 1945 E. Ninth Ave., the machine is the only one in Alaska.

Dr. Bill Faulkner, one of the physicians at the center, says that while the instrument "will not replace the traditional refraction techniques, it will prove invaluable in detecting the proper visual prescription. It will also be utilized in contact lens fitting procedures."

It's especially valuable in examinations of children or of patients with communication problems.

"We don't have to keep saying over and over to a patient, 'Which is clearer, this or this?' and that's a big help," the doctor said.

The machine, described as the 6600 auto-refractor, measures only distant vision. The ophthalmologist continues to make tests for glaucoma, muscle balance, near vision and general eye condition. And he refines the machine prescription to fit the patient.

To do this, he dials the machine's measurements into the trial lenses, then checks out its findings with his patient.

It can pick up early clues to glaucoma and cataracts by pointing out that not enough light is getting into the patient's eyes.

The computer-based machine was originally developed by the National Aeronautics and Space Administration to test the vision of astronauts.

Another space-age spinoff adapted to ophthalmologists' offices is the tonometer, which screens for glaucoma. Instead of actually touching the eyeball to test inner pressure, the new machine measures and records pressure by blowing a whiff of air into each eye. This device has been in use in local offices for a year

or so.

The refraction examination is simple. The patient looks directly into the computer screen, a technician at the opposite end presses a button, and he sees a pale green light, one eye at a time.

The readout tells the degree of nearsightedness or farsightedness, how much astigmatism is in each eye and where it's located on the eye's axis.

The machine, manufactured by Acuity Systems Inc. of Reston, Va., costs about \$28,000. Company technicians are here training clinic staff in use of the machine.

### Municipality of Anchorage ASSEMBLY AGENDA

3500 Tudor Road  
Assembly Chambers  
December 6, 1977  
6:00 PM-Special Meeting

- I. CALL TO ORDER
- II. ROLL CALL
- III. MINUTES OF PREVIOUS MEETINGS
  - A. Special Meeting of October 25, 1977
- IV. APPEARANCE REQUESTS AND COMMUNICATIONS
  - A. Mr. Lafayette M. Williams, regarding a new type of Physical Fitness.

# CHARLOTTE BRIEFS

## Eye Diseases To Be Topic

Dr. Philip Czyz will discuss diseases of the eye at Thursday's meeting of the American Association of Retired Persons.

The meeting will be at 1:30 p.m., in the Port Charlotte Civic Center, 440 South Easy Street. A question and answer period will follow the doctor's presentation.

← NOTE!

10/25/79 Port Charlotte (FL)

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11/19/79 Sarasota (FL)  
Herald Tribune

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



American Optometric Association

243 No. Lindbergh Boulevard  
St. Louis, Missouri 63141  
314-991-4100

FROM BETTER HOMES



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.

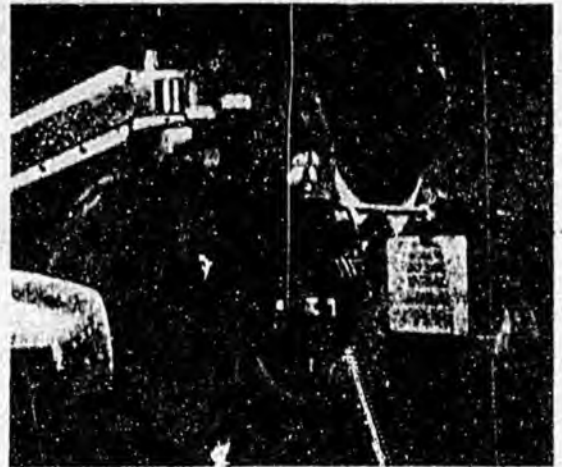
**4** Then the interior of your eyes should be examined for any signs of systemic or eye diseases. It is here that your optometrist can see blood vessels in their natural state and can therefore detect certain signs or symptoms of diabetes or hypertension. When signs or symptoms are discovered, you'll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

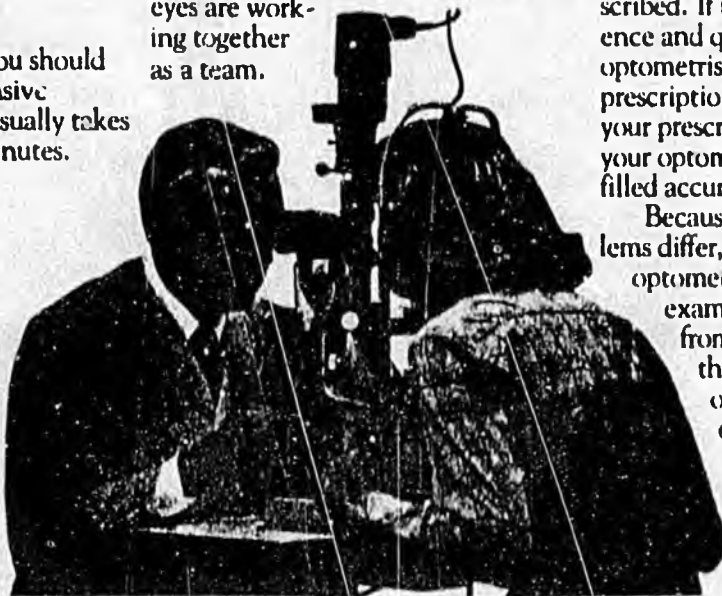
**7** Finally, the ability of your eyes to change focus easily from far to near and near to far should be measured.

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.

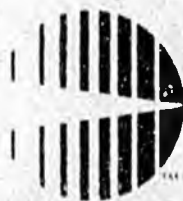


When your optometrist has completed your examination and evaluated all the results, corrective lenses or vision therapy may be prescribed. If that's the case, for convenience and quality assurance, your optometrist can properly fill your prescription. Or, if you decide to take your prescription elsewhere,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



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American Optometric Association

Whereas; permanent, irreversible damage to eyes have resulted from the inability to diagnose and recognize serious eye disorders by optometrists, the following referral guidelines are recommended:

Sec. 2 AS or 300 (2) is amended by adding a new section to read:

When an optometrist examines any person, he shall inform that person or a parent or other responsible party, prior to prescribing or providing eyeglasses or any other service, that examination by a licensed physician

is indicated whenever any of the following conditions is present. These conditions fall into the following categories:

- I. ABNORMALITIES OF VISION
- II. ABNORMALITIES OF TISSUE
- III. ABNORMALITIES OF MOTOR FUNCTION
- IV. OTHER ABNORMALITIES

ABNORMALITIES OF VISION:

- A. Failure on the part of an individual to obtain 20/20 vision in each eye, 20/40 in children under eight years of age by refractive correction by lenses unless the cause has been medically determined by a physician and is stable.
- B. A complaint by the individual of the sudden appearance of spots, flashing lights, scintillating images, transient dimming, less vision, or distortion in the shape of objects.
- C. A complaint by the individual of a temporary or permanent loss of any portion of the visual field, such as a curtain coming over the vision.
- D. History of seeing rainbows or halos around lights.
- E. Diplopia (Double Vision) of sudden onset.

ABNORMALITIES OF TISSUE:

- A. Presence of redness, swelling, masses, or ulceration of the eye or its surrounding tissue.
- B. Opacities of the cornea, lenses or vitreous.
- C. Changes in the appearance of the optic disc.
  1. A difference in appearance between the optic discs of each eye.
  2. A change in appearance of the optic discs from a previous exam.
  3. Suspicion of elevation of the optic nerve head.
- D. Observation of a deviation from the usual appearance of the retina or its vessels.

ABNORMALITIES OF MOTOR FUNCTION:

- A. Strabismus, a deviation of the eyes from their normal parallel position in straight ahead gaze or gaze in any direction.
- B. Difference in the size of the pupils or failure to constrict with illumination or with near vision.
- C. Ptosis or Lagophthalmos (Drooping of the eyelids).
- D. Nystagmus (Rapidly occilating eye movements).

OTHER:

- A. Continuous tearing of longer than 24 hours duration or complaints of watering eyes not associated with visual tasks.
- B. Intraocular tension of twenty-two or more, or family history of glaucoma.
- C. Any other observation of deviation from the normal appearance of the eye and related tissues, or any complaint that is not attributable to the refractive state or muscle balance or which is not amenable to lenses or prisms.
- D. Keratometry readings greater than 47.00 diopters or suggesting keratoconus.

Exception to any of the preceeding conditions would be previous evaluation by a physician and discharge from medical treatment and follow-up for that condition.

Failure to comply with the provisions of this act shall subject the offender to the revocation or suspension of his license to practice optometry.

Nothing in the provisions of this section or any other section pertaining to optometry shall apply to, nor in any way restrict the practice of medicine, or osteopathy, nor to any licensed physician, osteopath, nor any nurse, technician, medical assistant, optician, nor to any allied or auxiliary health personnel acting under their prescription, supervision or direction, nor to any eye screening, state or government eye testing program, nor to any eye teaching in any medical, osteopathic or nursing or allied health personnel school.

This act shall take effect immediately.

Over many years, ophthalmologists have seen the continued and perplexing problem of delayed or non-referral by optometrists. There are two reasons why ophthalmologists are concerned about this: 1. irreversible loss of vision can and has occurred. 2. the ophthalmologists eventually treat these people, and often we feel that some or more sight could have been preserved if earlier treatment had been instituted. The ophthalmologists feel that the optometrists are trained to recognize the symptoms of many diseases which may be discovered by history, visual acuity testing, refraction, tonometry and external examination. They are not permitted under recognized optometric standards to undertake a definitive diagnosis, but recognize this as the responsibility of the medical doctor, and to refer that person to a doctor. For these reasons, we feel that a 20/40 bill would help with the problem of delayed referral and non-referral.

In reviewing a small fraction of one ophthalmologist's files, we find 9 well documented cases of delayed or non-referral. It is our opinion that this resulted in harm or potential harm.

Case #1

This person complained of double vision to an optometrist. He was not referred to a medical doctor. Finally the patient came to an ophthalmologist where the diagnosis of myasthenia gravis was made. This disease can kill by respiratory arrest.

Case #2

This person went to an optometrist with an eye complaint and was told by the optometrist that he thought he had something bad and to come back tomorrow for a field. This patient finally went to an ophthalmologist and was determined to have a retinal detachment. It is well known by the ophthalmologists that the earlier the detachment is repaired the better the vision will be after the surgery.

Case #3

This person was a diabetic and had a cataract in the left eye. This person was told by an optometrist that it was not necessary to do anything about the eye. This person had an iritis or inflammation of the eye from leaking of lens protein. This

person finally went to an ophthalmologist and underwent immediate cataract surgery. It is well known by the ophthalmologists that this can lead to adhesion of the iris to the diseased lens and/or cornea, resulting in permanent glaucoma and irreversible loss of vision.

#### Case #4

This person went to the optometrist because of decreased vision. He was told that he had a cataract and to see an ophthalmologist about it. He was left with the impression that there was no hurry. This person's vision became worse and he then saw an ophthalmologist who determined that he had a retinal detachment. It is well known by ophthalmologists that early repair of retinal detachments not involving the central part of the retina most often results in 20/20 vision. But, if surgery is delayed and the central part of the retina (macula) detaches or pulls off, the visual outcome is poor.

#### Case #5

This child had difficulty with his school work and did not want to go to school. His parents were told by an optometrist that the child was malingering or faking. This child was seriously reprimanded by the parents. The child finally saw an ophthalmologist and was determined to have Stargart's disease. This condition is well known by the ophthalmologist to cause serious problem with vision.

#### Cases #6,7,8,9

All of these people were diabetics. The optometrists did not tell these people to see an ophthalmologist for their potentially serious eye manifestations of diabetes. By the time these people finally saw the ophthalmologist time had run out, serious eye problems of diabetes had already set in. It is well known by the ophthalmologist that early treatment with laser can preserve vision

Case #10

This is the well known Timothy Steele case. This child was seen by an optometrist in Fairbanks because his eyes were crossing. A dilating eye drop was used to dilate the child's eyes. The optometrist's record noted "No good reflex" in Timothy's right 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 Mr 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. Steel 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 Mr. Shank and it was then that he discovered that the vision in Timothy's right eye was limited to light perception. At this point, Mr. 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 of 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 Leterman 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.

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.

This case was tried by Judge James M. Fitzgerald, United States District Judge, District of Alaska. The Judges decision was:

"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 'judgement 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. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

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

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

ss: James M. Fitzgerald

It is thus obvious if this bill were passed then statutory law would be completely consistent with common law or court decision.

You will hear from the optometrists that they cannot get their people in to see the ophthalmologist immediately. But, what they do not tell you is that there is a city call schedule in both Fairbanks and Anchorage with an ophthalmologist available 24 hours a day to see people and all that has to be done is to call the emergency rooms to get the name of the ophthalmologist for that week, and that patient can be seen the same day. They have not told you that there are now new ophthalmologists that have started practice in the state and that more often than not they can get their people in with one of them the same day.

You will also hear from the optometrist that this bill will seriously restrict them, that this is a restraint of trade, that this bill is designed by the ophthalmologists to bring them more income. This simply is not true. The criteria of referral written into this bill are what is called the LeMoine criteria. This is what is taught in the schools of optometry as indications for referral to a competent medical doctor. This is even in their textbooks: "The Optometric Profession" by Hirsch and Wick. Why, then, are they apposed to this type of legislation when it merely reiterates in law what is considered by the textbooks of optometry as a standard of optometric practice?

The reason is economics, which is tied together very closely with a national attempt to change the standards of optometric practice, as well as public and governmental image. This is done by legislative "drug bills" and advertising. The essence of the court's decision in the Timothy Steele case was 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. See Tables I, Ia, Ib

## ECONOMICS AND PRACTICE?

Table 3<sup>5</sup> shows the substantial number of public dollars which are expended for eye care. A total of approximately \$4,135 million dollars were spent in 1975 for vision care services.<sup>6</sup> The national consumer spending for ophthalmic surgery is not listed. This would make the total ophthalmologic dollar spent on eye care, far greater than the optometric dollar. If optometrists are allowed to expand the scope of their practice through the use of diagnostic drugs, the price of the basic eye examination would undoubtedly rise. Proposed national health care legislation can be expected to impact heavily upon these figures. For example, if the Kennedy-Mills National Health Insurance proposal were to include coverage of sight correction services, total spending for these services would rise by 21% or \$866 million dollars per year. It is obvious that there will be considerable effort by optometrists to ensure their fullest possible participation in this program. The economic stakes are very high.<sup>7</sup> This makes it very clear why optometry has put on an aggressive nationally organized push to legislate themselves into a better position to compete for this consumer dollar. Even though optometrists in the State of Alaska suggest that this is not an "economic issue"---it is. The optometric opposition to this bill is due to continued effort toward the national optometric goal of attempting to become primary eye care providers.

This image change is being sold to the public by a sophisticated national advertising campaign. This multi-million dollar campaign is funded by the national optometric organization through dues and special assessments. They are trying to sell themselves as "your family doctor of optometry...the one to see and keep seeing". Calling themselves family doctors in the opinion of the ophthalmologists is misleading since they are not medical doctors as are the family practitioner or family doctor. These adds are occurring on national T.V., radio and magazines; such as, The Ladies Home Journal, Better Homes and Gardens, etc. Adds that show stethoscopes hanging around the neck of the optometrist is also misleading, as the general public associates the medical doctor with the stethoscope. One article in the Anchorage Times even referred to a group of optometrists as physicians and the word ophthalmologist was used. (see supporting documents)

Let us examine the basis for supporting the Lemoine criteria. In an article "How the General Practitioner can Determine The Need for Ophthalmologic Referral", it was shown that by history (listening to the patient's story), visual acuity and external examination by hand-held flashlight, most of the initial clues to eye disease are determined, 85% in fact.

Examination Elements That Indicated Ophthalmologic  
Disease in 716 Patients.

History	255	(35.6%)
Visual Acuity	198	(27.7%)
External Examination by Hand- Held Flashlight	157	(21.9%)
Refraction	4	(.6%)
Tonometry	69	(9.6%)
Slit Lamp	23	(3.2%)
Undilated Fundus	9	(1.3%)
Dilated Fundus	1	(.1%)
	716	100%

All of the Lemoine criteria of referral are symptoms of disease and require no instrumentation except for two: looking at the optic disk through an undilated pupil and chicking the "K" readings on a keratometer. No eye drops are needed, since the optic disc is in the posterior pole of the eye and simply putting the small aperature disk in place on the ophthalmoscope even the smallest pupil can be seen through. It is obvious from this article that detection of 99% of all eye disease is possible without dilation. All of these examining techniques can be done by the optometrist at this time in the State of Alaska.

In sum, to both the conscientious physician and the conscientious optometrist the need for referral of a patient to an ophthalmologist is usually obvious through the application of history, visual acuity, and external examination by hand-held flashlight, and does not require sophisticated instruments.

Most importantly, do not dilate the pupil. Routine tonometry according to established standards and viewing the fundus oculi through the undilated pupil are the additional needed methods. The use of mydriatic drugs to dilate the pupil risks precipitating acute narrow angle glaucoma by a 9:1 ratio over uncovering any hidden disease process.

By now you have heard from the optometrists that there is another law suit filed against an Anchorage optometrist. They also state that if they could dilate the pupil to look in that the law suit would not have been filed. Well, the optometrist dilated Timothy Steele's pupil and still a law suit was filed and was won by Timothy Steele. The falacy of this statement by the optometrists is clear in light of Judge Fitzgerald's decision and the article on what people need ophthalmologic referral.

If this bill were passed, it would clear up once and for all through statutory law that what is already clear through common law and optometric textbooks. Judge James M. Fitzgerald clearly states this in his decision:

"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 'judgement 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. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

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

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

ss: James M. Fitzgerald

United States District Judge

Thank you for your time and the opportunity to present the views endorsed by the State Ophthalmologic Association.

## How the General Practitioner Can Determine The Need for Ophthalmologic Referral

Henry S. Campell, MD, *Martinsville, Virginia*

**W**HEN should a patient be referred to an ophthalmologist? Are eye drops and sophisticated instruments needed to make the referral decision? These questions are crucial to the proper care of eye problems, whether the patient presents initially to a physician or to a non-medical practitioner.

This study delineates the ways in which the possibility of visual system disease can be recognized in non-ophthalmologic office practice.

### Method

The author, an ophthalmologist practicing in a semi-rural area of Virginia, documented 1,000 consecutive office patient visits from October 9, 1978, through December 14, 1978. Each of these visits was classified into one of three groups: no disease, new disease, and old disease. No disease meant that the patient had no significant complaints, may or may not have required glasses for normal visual acuity and had no findings of a significant medical problem. New disease meant that the patient gave a history suggesting significant visual system disease and/or was found to have significant visual system disease; new disease patients had not been seen or treated previously for this problem by the examiner or by his partner ophthalmologist. Old disease patients had a significant visual system disease which had been seen and/or treated previously by the examiner and/or by his partner ophthalmologist. Patients with concomitant old and new disease problems were classified according to the new problem. Patients with more than one old disease problem were classified according to the more serious problem.

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Submitted 1-12-79.

All patient examinations included history, visual acuity, external examination, slit lamp biomicroscope examination and a view of the fundus oculi through undilated pupils. Tonometry was done in all adult patients without infection. A dilated fundus examination was done in all patients scheduled for a routine examination plus those patients where history and/or other examination indicated the need. Visual field examinations were done where indicated.

### Results

In a mature ophthalmologic practice, one expects to see relatively few patients without disease. Indeed, the examiner in this study saw only 284 patients (28.4%) without disease and 716 (71.6%) with disease. In the diseased group, 491 (65.6%) were already under observation or treatment.

Table 1 lists the means by which disease was suspected. Notice the heavy preponderance of history, visual acuity, and external examination by hand-held flashlight as the initial clues to disease. These three are, of course, different facets of the same stone and could well be combined, i.e., if a patient states that he does not see well, and if his visual acuity is indeed decreased, then the patient's history is confirmed. In 610 (85.2%) of the 716 patients with disease, this triad

Table 1. Examining Elements That Indicated Ophthalmologic Disease in 716 Patients.

History	255	(35.6%)
Visual Acuity	198	(27.7%)
External Examination by Hand-Held Flashlight	157	(21.9%)
Refraction	4	(.6%)
Tonometry	69	(9.6%)
Slit Lamp	23	(3.2%)
Undilated Fundus	9	(1.3%)
Dilated Fundus	1	(.1%)
	716	100%

indicated visual system disease. Refracting four high myopes or noticing thick spectacle lenses would have indicated the need for careful indirect ophthalmoscopy for peripheral retinal abnormalities.

The majority of patients with new disease presented with acute processes, such as infection, iridocyclitis, foreign bodies and the like; here history, visual acuity and external examination by hand-held flashlight again gave the clue. Those patients with old disease had chronic disorders such as cataracts and glaucoma; for these, tonometry and slit lamp examination added meaningful information. The 69 patients found to have glaucoma could have been suspected of the disease by using Schoitz tonometry or non-contact "air puff" tonometry. The nine patients found to have optic atrophy, glaucomatous cupping, diabetic retinopathy, and macular degeneration were suspected by viewing the fundus oculi through the undilated pupil.

Slit lamp biomicroscopic examination gave the clue in 23 of the 716 patients with disease, mainly for diseases of the cornea, silent iridocyclitis, and potential narrow-angle glaucoma. Two new and seven old patients with potential narrow-angle glaucoma were seen. Dilating the pupils of these nine patients could have precipitated disastrous attacks of acute narrow-angle glaucoma, and mydriatic eye drops were distinctly contraindicated.

An asymptomatic superior retinal hole was found in one patient because the history of retinal detachment in the other eye made an extraordinarily diligent search of the retina mandatory. Without this history and with only a routine examination of the retina, the hole would have been missed by the examiner.

Only one patient had a significant abnormality which was not suspected prior to dilating the pupil. Although her benign choroidal nevus was known to her from an examination about one year prior, she did not reveal this to the examiner initially.

Table 2 sums up how disease was suspected in the 716 patients found to have visual system problems.

### Conclusions

How, then, can the non-ophthalmologic practitioner know when a patient should be referred to an ophthalmologist? Most often, the study shows, through the basic medical triad of history, visual acuity, and looking at the external eye with a flashlight. Family physicians can take heart at this. And they may be cheered as well to know that the success of this triad obviates the need for sophisticated instruments: In only 23 of the 716 patients suspected of having dis-

**Table 2. How the Non-Ophthalmologic Practitioner Could Have Determined the Need for Ophthalmologic Referral in 716 Patients.**

History, visual acuity, external examination (the basic medical triad)	610/716	(85.2%)
History, visual acuity, external examination, undilated fundus	619/716	(86.5%)
History, visual acuity, external examination, undilated fundus, tonometry	688/716	(96.1%)
History, visual acuity, external examination, undilated fundus, tonometry, noticing thick spectacle lenses	694/716	(96.6%)
History, visual acuity, external examination, undilated fundus, tonometry, noticing thick spectacle lenses, slit lamp	715/716	(99.9%)

**NOTE:** In nine of the above 716 patients, dilation of the pupil with eye drops could have induced an attack of acute narrow-angle glaucoma.

ease was an instrument required that is not in the office of most physicians, namely, a slit lamp.

As for eye drops, the recommendation is BEWARE. Eye drops can, in certain cases, change a chronic visual problem into a dangerous emergency. Nine patients seen in this study, as noted, had the potential for acute narrow-angle glaucoma, and dilating the pupils of any of these nine patients could have produced an extreme emergency in the office of the general practitioner or non-medical optometrist. Moreover, eye drops may precipitate alarming side effects; in the course of this study two patients with corneal foreign bodies became faint, with decrease in blood pressure and nausea, after application of topical anesthetic drops (although neither patient had a seizure or total loss of consciousness).

In sum, to both the conscientious physician and the conscientious optometrist the need for referral of a patient to an ophthalmologist is usually obvious through the application of history, visual acuity, and external examination by hand-held flashlight, and does not require sophisticated instruments.

Most importantly, do not dilate the pupil. Routine tonometry according to established standards and viewing the fundus oculi through the undilated pupil are the additional needed methods. The use of mydriatic drugs to dilate the pupil risks precipitating acute narrow-angle glaucoma by a 9:1 ratio over uncovering any hidden disease process.

### Acknowledgment

The author thanks Donald W. Richman, MD, and Douglas M. Rampona, MD, for their assistance and advice.

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ALLOW ME TO INTRODUCE MYSELF -- MY NAME IS MARVIN GRANDAHL.

I AM GRADUATED FROM THE UNIVERSITY OF MINNESOTA WITH A BACHELOR OF ARTS DEGREE.

I AM A GRADUATE OF THE UNIVERSITY OF MINNESOTA MEDICAL SCHOOL.

I HAVE COMPLETED MY PH.D. THESIS WORK IN PHYSIOLOGY AT THE UNIVERISTY OF MINNESOTA. AT THAT TIME, I WAS A TEACHING ASSOCIATE IN THE DEPARTMENT OF PHYSIOLOGY AND A CARDIOVASCULAR RESEARCH FELLOW. I WAS ALSO A NIH RESEARCH FELLOW DURING THAT TIME.

I WAS AN OPHTHALMOLOGY FELLOW AT THE MAYO CLINIC IN ROCHESTER, MINNESOTA.

I AM NOW AN OPHTHALMOLOGIST IN PRIVATE PRACTICE IN ANCHORAGE, AND WICH TO URGE YOU TO HELP DEFEAT HOUSE BILL #75 AND SENATE BILL #79.

In reviewing House Bill #75 and Senate Bill #79, Section 2, Subsection 08.72.305 - Use of Drugs for Diagnosis, included in the list of drugs proposed to be used is a class of drugs called miotics. This group of drugs is only therapeutic and has no diagnostic use. They are used for treating chronic glaucoma and acute angle closure glaucoma. What is a therapeutic drug doing in a "diagnostic" bill?

Mr. George Hall's and Mr. Sternberg's (both Anchorage optometrists) response to this question at the March 1, 1978 meeting of the Legislative Coalition of Health Care Professionals in Anchorage and at the 1978 hearings on a similar bill introduced and defeated last year respectively was: "To take care of angle closure." "To use this as a first aid measure." This is treatment.

Treating angle closure glaucoma is very difficult and requires more than just putting a miotic eye drop in the eye. Treatment of this condition requires surgery in all cases. To break the angle closure attack before surgery, hospitalization, Diamox and intravenous Mannitol is necessary in many cases. If angle closure glaucoma goes untreated, blindness results. All cycloplegics and mydriatics (dilating drops) can cause angle closure glaucoma.

It has been suggested to you by the optometrists that the incidence of angle closure glaucoma is only 1 in 18,400 cases. What they do not tell you is that a unique situation exists with the native Alaskan. The incidence of angle closure is 1 in 1,900 cases and even higher if dilating drops are used. This problem usually takes several hours to develop, long after the optometrist would have left the village. If we were to allow the optometrists to use dilating drops, this would result in many more unnecessary surgical emergencies and possible blindness. In view of this well known fact, ophthalmologists are hesitant to use mydriatics and cycloplegics in the Alaska native, especially in the bush areas.

Miotics are a therapeutic class of drugs and are listed incorrectly in the proposed bills as diagnostic drugs. Either the optometrists do not have a thorough understanding of the eye medications, or they are asking the legislators to allow them to treat glaucoma and other eye conditions. The proposed bill lists only broad general categories of the desired eye medications, no 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 effects.

Cocaine, a topical anesthetic and mydriatic (dilator of the pupil) is a Class II narcotic controlled substance which is subject to wide spread abuse by addicts and requires a controlled substance registration certificate to dispense or use.

Optometrists are not medical doctors and cannot get a federal narcotics certificate. These drug bills are inconsistent with federal regulation on this point.

Atropine and Scopolamine are cycloplegic agents which paralyze the eye's focusing power and in sufficient doses produce irritability, hallucinations and even coma. Phenylephrin (a mydriatic) has the ability to raise the blood pressure markedly and to alter the rhythm of the heart and has been implicated in deaths in older people through strokes and in children through cardiac arrhythmias. Phospoline 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.

The above are only a few examples demonstrating what potential dangers exist in the various classes of 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.

## I. EYE HEALTH CARE PROVIDERS OF THE CONSUMING PUBLIC

The American Optometric Association defines an optometrist as:

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

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

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

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

Furthermore, this construed dilemma is removed by a landmark decision by Judge James M. Fitzgerald, United States District Judge for Alaska in the Timothy Steele case in Fairbanks, Alaska. This is the case where an optometrist in Fairbanks used a dilating drop and noted an abnormality and did not refer the child to a medical doctor. The following is a direct and full quote of the 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. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

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

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

ss: James M. Fitzgerald  
United States District Judge

If these bills passed, the statutory law would be inconsistent with common law or court decisions. Let us examine the optometrist's construed dilemma a bit closer. In an article "How the General Practitioner Can Determine the Need for Ophthalmologic Referral", it has been shown that the initial clues to eye disease are determined by history, visual acuity and external examination by handheld flashlight. Only .1% of eye disease is initially determined by using dilating drops. See Table A.

In sum, to both the conscientious physician and the conscientious optometrist the need for referral of a patient to an ophthalmologist is usually obvious through the application of history, visual acuity, and external examination by hand-held flashlight, and does not require sophisticated instruments.

Most importantly, do not dilate the pupil. Routine tonometry according to established standards and viewing the fundus oculi through the undilated pupil are the additional needed methods. The use of mydriatic drugs to dilate the pupil risks precipitating acute narrow angle glaucoma by a 9:1 ratio over uncovering any hidden disease process. Thus it is obvious that there is no dilemma at all. This dilemma was construed by the optometrist for legislative purposes.

By now you have heard from the optometrists that there is another law suit filed against an Anchorage optometrist. They also state that if they could dilate the pupil to look in that the law suit would not have been filed. Well, the optometrist dilated Timothy Steele's pupil and still a law suit was filed and was won by Timothy Steele. The fallacy of this statement by the optometrists is clear in light of Judge Fitzgerald's decision and the article on what people need ophthalmologic referral.

The ophthalmologist is a medical doctor who has completed a 3-5 year residency program after one year internship preceded by 4 years of college and 4 years of medical school. He is trained in the diagnosis and treatment of ocular dysfunction and disease and in the use of all techniques or treatment including drugs, surgery, laser photocoagulation, radiation, etc. Because he has been trained as a general physician first, his perspective of the eye is broader than the optometrist. He views the eye and its diseases within the context of the whole body physiology and pathology. Further, refraction to the ophthalmologist is viewed as only one necessary step in a differential diagnosis of the patient's complaint. Table 1 demonstrates the overall education and numbers of optometrists and ophthalmologists. From Table 1 it is evident that the ophthalmologists have much more training in pharmacology and pathology than the optometrists. Still the optometrists continue to compare their curriculum hours to dental school hours. They continue to say that if the dentists can use medications, why can't we. This is like comparing apples to oranges. They are not asking to use the drugs dentists use or to diagnose oral pathology. They are asking to do what the ophthalmologist does.

Therefore, it is more appropriate to compare ophthalmologists curriculum hours to optometric curriculum hours. (Please read Ref.#43, which explains this point in detail for the State of Alaska.) It is immediately obvious that the ophthalmologist has many more hours of classroom or book learning and many more years of clinical experience. The optometrists indicate that they can also take courses, but where do they get the years of clinical experience of putting drugs into the eyes of patients under close supervision of the clinical medical professors who are medical doctors. Optometrists simply do not get this type of training. Book learning is one thing, but clinical experience is most important.

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

#### ECONOMICS (AND PRACTICE)?

Table 3<sup>5</sup> shows the substantial number of public dollars which are expended for eye care. A total of approximately \$4,135 million dollars were spent in 1975 for vision care services.<sup>6</sup> The national consumer spending for ophthalmic surgery is not listed. This would make the total ophthalmologic dollar spent on eye care far greater than the optometric dollar. If optometrists are allowed to expand the scope of their practice through the use of diagnostic drugs, the price of the basic eye examination would undoubtedly rise. Proposed national health care legislation can be expected to impact heavily upon these figures. For example, if the Kennedy-Mills National Health Insurance proposal were to include coverage of sight correction services, total spending for these services would rise by 21% or \$866 million dollars per year. It is obvious that there will be considerable effort by optometrists to ensure their fullest possible participation in this program. The economic stakes are very high.<sup>7</sup> This makes it very clear why optometry has put on an aggressive nationally organized push to legislate themselves into a better position to compete for this consumer dollar. Even though

the optometrists in the State of Alaska suggest that this is not a "money bill"-- it is. It is merely the first step toward the national optometric goal to attempt to become primary eye care providers.

This image change is being sold to the public by a sophisticated national advertising campaign. This multi-million dollar campaign is funded by the national optometric organization through dues and special assessments. They are trying to sell themselves as "your family doctor of optometry...the one to see and keep seeing". Calling themselves family doctors in the opinion of the ophthalmologists is misleading since they are not medical doctors as are the family practitioner or family doctor. These adds are occurring on national T.V., radio and magazine; such as, The Ladies Home Journal, Better Homes and Gardens, etc. Adds that show stethoscopes hanging around the neck of the optometrist is also misleading, as the general public associates the medical doctor with the stethoscope. One article in the Anchorage Times even referred to a group of optometrists as physicians and the word ophthalmologist was used. (See supporting documents)

We should expect that in the future the Alaskan optometrists will follow the attempt of other state optometric associations to next try for the privilege to use these same diagnostic drugs as therapeutic agents. An attempt was made in West Virginia to legislate the privilege of eye surgery, but this was defeated.

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

Table 1 indicated the total number of practitioners in each group.<sup>8</sup> The median number of patients seen per week by optometrists was 43.2; the median seen by ophthalmologists was 102.9. The ophthalmologist sees more than twice as many patients as the optometrist while he comprises only 30% of the work force. It is therefore, clear that the ophthalmologists care for half the patients, while the optometrists, comprising 70% of the national work force, care for the other half. The statistics in Alaska show that there is a total of 40 optometrists<sup>10</sup> and 25 ophthalmologists<sup>10</sup>. Thus the ophthalmologists make up 39% of the state work force

and the optometrists 61%. Applying the same national ratio of eye consumers seen by optometrists and ophthalmologists, it is evident that the ophthalmologists see 56% of the eye care consumer, but makes up 39% of the state work force. The accuracy of the ratio of two to one was checked in the city of Anchorage by comparing the number of eye consumers seen by the most active ophthalmologist in town - 40-50 eye consumers, as compared to the most active optometrists in town - 20-25 eye consumers seen in one day. The average ophthalmologist in Anchorage sees 30 people per day. The average optometrist sees 15 people per day. These figures would seem to indicate that although ophthalmologists are a smaller group than optometrists, the public will seek out their services given a free market choice.<sup>11</sup> On this point, the eye consumer in the state of Alaska has ready access to the ophthalmologic eye care providers. Some of the states in the lower 48 are mainly rural and ophthalmologists are congregated in the metropolitan areas and the optometrists are distributed over the rural areas. However, much of Alaska is "bush country", so that the ophthalmologists and optometrists are both congregated in Anchorage, Fairbanks, Kenai Peninsula and the southeast. There are only two areas (Kodiak and Bethel) that have a full time optometrist and no full time ophthalmologist, Table-Map 5,6. However, there are other medical doctors in these communities with "medical know how" and there are airports for evacuation in the case of eye emergencies. Furthermore, Kodiak and Bethel are visited on a regular basis by itinerant ophthalmologists. In fact, most areas in Alaska are served by itinerant ophthalmologists both by Alaska Native Service and by private practicing ophthalmologists, Table-Map<sup>6</sup>. In the 14 other states where a similar bill was passed, these states were mainly rural with a maldistribution of ophthalmologists. In these states, this was the main reason for passing the legislation. Therefore, this argument for passing House Bill 74 or Senate Bill 75 does not apply to the State of Alaska, because the distribution of ophthalmologists is essentially identical to that of the optometrists. Thus, the health services of ophthalmologists are readily available to

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

In the states where optometric drug laws are in effect, optometrists who wish to use drugs much take short slide and lecture courses on pharmacology. This has or will create two classes of optometrists, which can only lead to additional consumer confusion about a profession already shrouded in confusion. In addition, the use of drugs by optometrists could falsely lead patients to believe diagnostic expertise is available from optometrists.

It is misleading to the consumer and legislature to imply that any drug is purely diagnostic. Each of the classes of drugs asked for by optometry have therapeutic uses. Will the optometrists resist the temptation to use these drugs to treat conditions beyond their knowledge and skill?

It has been said by the optometrists that they would like to use dilating eye drops also in their bush clinics when they see Alaska natives. A unique situation exists within the native population of Alaska. The incidence of angle closure glaucoma is 1 in 1,200, not 1 in 20,000 as in caucasians. To allow the optometrist to use these dilating eye drops would result in many more cases of acute angle closure glaucoma, for which they are not trained to treat, and which requires quick and effective treatment to prevent blindness. Sometimes angle closure glaucoma requires administration of intravenous Diamox, Manitol or urea. This would result in further expenditure of health care dollars.

### III. LEGISLATIVE DUTY FOR THE EYE CARE CONSUMER:

As practitioners of an occupation which deals with the integrity of eyesight, optometrists have been recognized by the Washington Legislators as members of a "learned profession".<sup>12</sup> Professionals who deliver health care may be regulated by the state via its

police powers to oversee those activities which are involved with health, education and welfare.<sup>13</sup> The healing arts particularly have been the subject of regulatory legislation which specifies strict requirements for the practice of such professions.<sup>14</sup> The intent of such restrictive legislation is avowedly the protection of the public against injuries it may suffer from the conduct of such business or calling.<sup>15</sup> The state may reasonably impose any condition precedent to the grant of its consent to practice a healing art, which has a real and rational relation to that objective.<sup>16</sup>

The usual means taken by the state in applying these conditions as quality standards has been by imposing licensing requirements and by carefully defining the particular professions involved.<sup>17</sup> Constitutional challenges to this power of the state have been universally defeated when that power has been reasonably exercised.<sup>18</sup>

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

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

The justification for such regulations lies in a perceived right and duty of the legislature to protect the citizens of the state from incompetents and fraudulent health practitioners.<sup>22</sup> The Washington Constitution specifically vests exclusive authority in the legislature to:

"...regulate the practice of medicine and surgery and the sale of drugs and medicines."<sup>23</sup> From this, courts have construed legislative authority to regulate, by means of separate statutory licensing requirements, all of the various professions and occupations engaged in health care delivery. This includes many professions which are not obviously included in "...the practice of medicine..."<sup>24</sup> Further, the state has the power to define what constitutes the practice of any profession and may then confine practitioners of various health disciplines to the particular system of practice in which they have been educated.<sup>25</sup>

This is a logical stance for the legislature to take. If the legislature has an avowed interest in protecting the public,<sup>26</sup> it must make some attempt at defining the scope of appropriate practice which each class may safely employ and to license those within each class to practice upon the public only those skills for which they have demonstrated competent training. That includes courses, testing and most important of all, clinical experience under supervision. This is the legislative intent in enacting licensing statutes.<sup>27</sup> This reasoning is followed with consistency in cases involving almost every viewpoint and aspect of health care.<sup>28</sup>

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

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

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

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

- a) Goal - As noted above, the frequently given objective for regulation of health care providers is the protection of the public from incompetent practitioners.<sup>31</sup>

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1) The members of the Board of Optometry have little personal experience in ocular pharmacology, ocular pathology, and diagnosis. They are themselves graduate of optometry schools which have offered limited training because the board members took their training when little time was devoted to course work in pharmacology, and now have little experience with drugs. It is difficult to see how such a Board can adequately evaluate such clinical ability in optometric applicants for licensure, nor is it clear how such a Board can construct any 'refresher' course that would adequately prepare the optometrist for his broadened responsibilities. What is usually used is a 'canned' course, prepared elsewhere.
- 2) The ability of the Board to carry out its mandate to protect the public from those few individuals that would use these diagnostic drugs also as therapeutic drugs would find themselves in a frustrated position. The Board can do nothing to prevent this and the fine for practicing medicine without a medical license is only \$100.00.

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

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

#### V. CONCLUSION

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

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

- 1) optometric training must be upgraded substantially enough to provide him with clinical expertise sufficient to satisfy appropriate public expectations of high competency; or
- 2) optometrists must work in an association with ophthalmologists close enough to provide for the day-to-day transmission of diagnostic information from the M.D. to the O.D., and allow the latter to obtain practical involvement in treatment rationals and administration. This would be similar to the military, Veterans Administration and Alaska Native Service, where the optometrist use these drugs under the direct supervision of the ophthalmologists.<sup>47</sup>

Having once recognized the above solutions two problems immediately present themselves. The first solution would require the relocation of optometric schools to permit integration with medical training and include a complete restructuring of optometric training. So much change would be needed that any difference between the ophthalmologist and optometrist would evaporate. However, if any group of practitioners presumes to medically minister to the public it must accept the rigorous training which must precede such responsibility. There is no quick and easy path to competent understanding of a subject becoming increasingly complex year-by-year. The optometrists seem to want to become doctors, but do not want to go through the extensive number of years training it requires. This is particularly true when the results of error or incompetency can be blindness.

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

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

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

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

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

FOOTNOTES:

- 1 - Worthen: The Ophthalmologic-Optometric Interface. Transactions of American Academy of Ophthalmology and Otolaryngology \*3:OP-155, 1977
- 2 - Representativ of most ophthalmology residency programs, it is that of the University of Minnesota, Mayo Clinic Graduate School of Medicine. Following graduation from Medical school and a general or specialty internship, the resident enters a program which requires 65 hours a week of ophthalmologic instruction; of this, approximately 6 hours a week is devoted to formal, diadactic lecture, the remainder is clinical or laboratory activity. This weekly schedule continues over a twelve month academic year, for three years. Some of a nine month written home study course administered by the Academy of Ophthalmology. Some programs require an additional one year of ophthalmology. Department of Ophthalmology, University of Minnesota, Mayo Clinic Resident 1974-1977.
- 3 - Curriculum, University of Minnesota College of Medicine. The basic curriculum required of any candidate for an M.D. degree includes 128 credit hours of 'medical' subjects; this does not include clinical studies which are specifically directed toward a specialty interest. Although optometrists may agree that these requirements are not appropriate for them, such an analysis ignores the fact that in expanding their role into the practice of medicine optometrists should be subjected to the same educational requirements. Unfortunately, there is no short-cut to professional competence. This is particularly true in the rapidly expanding and complex field of medicine. The public has a right to demand strict legislative requirements before practitioners are certified as competent.
- 4 - Worthen, note 1, OP-158, supra.
- 5 - Trapnell, The Impact of National Health Insurance on the Use and Spending for Sight Correction Service, 1976. (This study was underwritten by the American Optometric Association, and the Optical Manufacturers Association.) It reveals that optical device sales represent 66% of the funds expended for optometric services and 19% of funds expended for ophthalmologist services, at Tabel 1 of the Trapwell Study.
- 6 - This figure includes \$920 million spent for optician and \$220 spent by institutions. Those categories of service providers are not included in this discussion since they are not involved in patient care.
- 7 - This economic impact will be divided not only by optometrist and ophthalmologists, but also by opticians and lens/fram/contact lens manufacturers.

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

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

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

10- Department of Commerce and Occupational Licensing

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

12- R.C.W. 18.53.005 Legislative Declaration: "The legislature finds and declares that the practice of optometry is a learned profession and affects the health, welfare and safety of the people of the this state, and should be regulated in the public interest and limited to qualified persons..." (Amendment 1975)

- 13 - Ellstad v. Swayze, 15 Wash. 2<sup>d</sup> 281, 130 P2<sup>d</sup> 354 (1942).  
See also, Ketchum v. King Co. Medical Service Corp., 81 Wash 2<sup>d</sup> 565, 502 P2<sup>d</sup> 1197, 1200 (1973)
- 14 - Swayze, note 13, 353, supra.
- 15 - Kelly v. Carroll, 36 Wash 2<sup>d</sup> 482, 219 P2<sup>d</sup> 79, 90. (1950)
- 16 - Campbell v. State, Id., at 462
- 17 - Gellhorn has recently argued that state licensing statutes are in fact attempts by the profession or occupation involved to control competition by means of restrictive admission to practice. Even Professor Gellhorn would admit that the licensing of health professions is necessary and probably rises above such criticism. Gellhorn, The Abuse of Occupational Licensing, 44 University of Chicago L.R.6, 1976.
- 18 - Semmler v. Oregon State Dental Examiners, 294, U.S.608, 611, (1934); State v. Wilson, 11 Wn. App. 916, 528 P2<sup>d</sup> 279 (1974)
- 19 - R.C.W. 18.53.140
- 20 - Laughney v. Maybury, 145 Wash. 146, 259 P.17 (1927)
- 21 - Ellstad v. Swayze, note 47, 353, supra, Accord. Dantzler v. Callison, 230 S.C. 75, 94 WE 2<sup>d</sup> 177, app. dismd. 352 U.S. 939(1956)
- 22 - Kelly v. Carroll, note 15, 85, supra.
- 23 - Art. 20, 2
- 24 - Ellstad v. Swayze, note 13, 353, supra.
- 25 - State v. Bonham, 93 Wash 489, 161 P 377, 379 (1916)
- 26 - Kelly v. Carroll, note 22, supra.
- 27 - State ex rel Fleming v. Cohn, 12 Wash 2<sup>d</sup> 425, 121 P2<sup>d</sup> 954 (1942) Accord, State v Hauk, 32 Wash 2<sup>d</sup> 68; 203 P2<sup>d</sup> 693(1949)
- 28 - 61 Am Jan 2<sup>d</sup>, Physicians, Surgeons, and other Healers, 19;86 ALR 623, 624
- 29 - Ex parte Whitly, 144 Cal. 167, 77 P 879 (1904)
- 30 - "It is enough that...it might be though that the particular legislative measure was...rational..." Williamson v. Lee Optical Co., 348 U.S. 483, 488 (1955), Douglas, J., majority opinion)
- 31 - See note 15, supra.
- 32 - Campbell v. State, note 15, supra.
- 33 - "A law which reduces or prevents any increase in an ...evil tends to safeguard the public welfare..." Id. at 462. (emphasis added).
- 34 - Williamson v. Lee Optical, note 29, supra.
- 35 - State v. Houck, note 27, 700, supra.
- 36 - Worthen, note , Op-160, supra.
- 37 - "...the legislature was careful to require definite knowledge

- 38 - West Virginia Statute 30-8-5 requires those optometrists who wish to use drugs to complete those requirements which the board of optometry may see fit to establish. The board of optometry requires attendance at a pharmacology course similar to that described in note 43, infra.
- 39 - Ellstad v. Swayze, note 13, supra.
- 40 - Campbell v. State, note 15, supra.
- 41 - R.C.W. 18.54070
- 42 - R.C.W. 18.54.030 - In fact, the statute excludes from board membership any optometrist "...who has any connection with any school...of optometry..." It could be presumed that optometrists teaching at optometric schools would be best qualified to judge the qualifications of optometric candidates and possess the most currency in clinical information.
- 43 - A letter from Leon Candemb, O.D., Director Pennsylvania College of Optometry describes the lecture outlining in pharmacology used by Kentucky, Florida, Pennsylvania and New Mexico. This course involves participation by the optometrist in six weekend sessions (Saturday and Sunday) and ends with a three hour examination covering the presented material. A letter from Sam A. McConkey, M.D. to the Honorable Charles Parr:

#### ON OPTOMETRISTS PRACTICING IN THE STATE OF ALASKA

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

- 24 attended Pacific University College of Optometry (1951-1976)
- 5 attended Illinois College of Optometry (ICO)
- 4 from 1948 to 1960 and 1 graduated in 1977
- 3 attended Southern College of Optometry
- 2 attended the University of Houston College of Optometry
- 1 attended Southern California College of Optometry
- 1 attended Los Angeles College of Optometry (No longer listed as an optometric school)
- 1 attended Northern Illinois College of Optometry (No longer listed as an optometric school)

In one case, it is unknown to the Department of Commerce where he went to school.

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

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

Illinois College of Optometry, prior to 1960, had NO M.D., Ph.D., or anyone with a masters or bachelors degree in pharmacology teaching. The one graduate of 1977 may have been taught by one professor in the category of Ph.D. or masters or bachelors degree.

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

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

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

It follows that at least from all the available evidence, the maximum number of optometrist in the state that had any pharmacology training from any qualified instructor at all, is two; one from the Illinois College of Optometry who graduated in 1977 and the one graduate of Southern Calidifornia College of Optometry. It appears that the maximum number of optometrists in the state that had any pharmacology training from any M.D. or M.D./PhD. in pharmacology is zero.

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

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

44 - State v. Spino, 61 Wash 2<sup>d</sup> 246, 377 p2<sup>d</sup> 868, 870 (1963)

45 - Pennington v. Benelli, 15 Cal App 2<sup>d</sup> 316, 59 P2<sup>d</sup> 448

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

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

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

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

48 - The optical Journal and Review of Optometry, June 15, 1976  
Volume 113 No. 6

TABLE A. EXAMINING ELEMENTS THAT INDICATED OPHTHALMOLOGIC  
DISEASE IN 716 PATIENTS.

HISTORY	255	(35.6%)
VISUAL ACUITY	198	(27.7%)
EXTERNAL EXAMINATION BY HAND- HELD FLASHLIGHT	157	(21.9%)
REFRACTION	4	(.6%)
TONOMETRY	69	(9.6%)
SLIT LAMP	23	(3.2%)
UNDILATED FUNDUS	9	(1.3%)
DILATED FUNDUS	<u>1</u>	<u>(.1%)</u>
	716	100%

TABLE I

## SYMPOSIUM ON LEGISLATION

PH. D. THESIS BY DON C. PEARSON, M. D. - APRIL 28, 1977 - WORTHEN  
 THE OPHTHALMOLOGIC OPTOMETRIC INTERFACE T. A. A. O. O. 1977

Comparison of Optometry and Ophthalmology

	Optometrists	Ophthalmologists
1 - License	In all states as optometrists	In all states as Physicians and Surgeons
2 - Prerequisite	2 yrs. of college (60% of beginning students have baccalaureate degree or higher)	Graduation from Medical School (M.D.) 3 - 4 years College
3 - Curriculum	School or College	Medical school internship, Postgraduate (residency)
Pharmacology	64 hours* 126 hours **	307*** (187 hrs. general with 18 months clinical and 120 hrs. ocular with 4yrs. 6mo. clinical)
Pathology	20-60 hours	200 hours general with 3 years clinical and 148 hours ocular with 3 years clinical
4 - Period of training	4 yrs (34-36 months)	3-5yrs. (36-60 months)
5 - Time for education after high school	6-8yrs (54-72 months) Max. 4yr. undergrad. Max. 4yr. Opt. college	11-14yrs. (120 months)
6 - Number of active practitioners	21,900	9,322
7 - Number of students	4,985	1,914 (residents)
8 - Total number of practitioners and students	24,933	10,496
9 - Total number of eye professionals	24,800 (70% of total)	10,629 (30% of total)

\* Mr. George Hall's report on Pennsylvania School of Optometry to March 1, 1978 meeting of Legislative Coalition of Health Care Professionals.

\*\* 126 hours - Southern College of Optometry

\*\*\* Mayo Clinic and Iowa

TABLE 1A

## OPTOMETRIC EDUCATION DEFICIENCY DOCUMENTED FOR REDBOOK SURVEY

As prepared by John W. Gamel, M. D.  
University of Louisville School of Medicine

EDUCATIONAL BACKGROUND REQUIRED FOR DELIVERY OF EYE CARE:  
Comparison between Optometry and Ophthalmology\*

REQUIREMENT	OPTOMETRY	OPHTHALMOLOGY
Admission	2 years of college	4 years of college plus 4 years of medical school
Total Training after High School	6 years	12 years
Class and Laboratory Time	1,650 hours	3,249 hours
Supervised Practice of General Medicine (Internal Medicine, General Surgery, Obstetrics-Gynecology, Psychiatry, Primary Care)	0 hours	3,240 hours
Supervised Practice of Medicine and Surgery of the Eye	0 hours	5,240 hours
TOTAL TRAINING HOURS	1,650 hours	11,739 hours
Number of years during which training occurred	4 years	7 years
Hours per year	412½ hours	1,677 hours

## \*Information abstracted from:

1. Course Handbook of Indiana University, Division of Optometry, 1975-76.
2. American Association of Medical Colleges Curriculum Directory, p. 86 87 (re: University of Louisville School of Medicine.)
3. Residency Training Schedule, Department of Ophthalmology, University of Louisville.

TABLE 1b

## BREAKDOWN OF HOURS SPENT IN EDUCATION OF OPHTHALMOLOGIST

1. Class & Laboratory:		
Medical School		
1st year	871	
2nd year	<u>748</u>	1,619
2. Residency:		
Lectures:		
5 hrs per wk x 150 weeks	750	
Basic Science		
40 hrs per wk x 10 weeks	400	
Home Study		
20 hrs per mo x 24 mos	<u>480</u>	1,630
TOTAL DIDACTIC TRAINING (HRS.) (1 + 2)		3,249
3. Supervised Practice of General Medicine		
54 wsk x 60 hrs. per wk (includes night calls & weekends)		3,240
4. Supervised Practice of Medicine and Surgery of the Eye		
35 hrs per wk x 150 weeks		5,250
TOTAL TIME SPENT IN SUPERVISED PRACTICE (HRS.) (3 + 4)		8,490
TOTAL TIME SPENT IN FORMAL EDUCATION OF OPHTHALMOLOGIST AT THE UNIVERSITY OF LOUISVILLE (HRS.) (1 + 2 + 3 + 4)		11,739

RESIDENCY TRAINING SCHEDULE, DEPARTMENT OF OPHTHALMOLOGY  
UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINESummary of Hours of Didactic Learning  
Offered During Residency:

## Ongoing Lectures:

Monday, a.m.	1 hour
Tuesday, a.m.	1 hour
Thursday, a.m.	2 hours
Friday, a.m.	1 hour
TOTAL:	5 hours per week

## Basic Science Courses:

40 hrs. per wk lectures/labs  
Duration: 10 weeks

## Home Study Course:

20 hrs per month

TABLE 2

PH. D. THESIS BY DON C. PEARSON, M. D. - APRIL 28, 1977 - WORTHEN  
 THE OPHTHALMOLOGIC OPTOMETRIC INTERFACE T. A. A. O. O. 1977

Service offered by Optometrist and Ophthalmologist

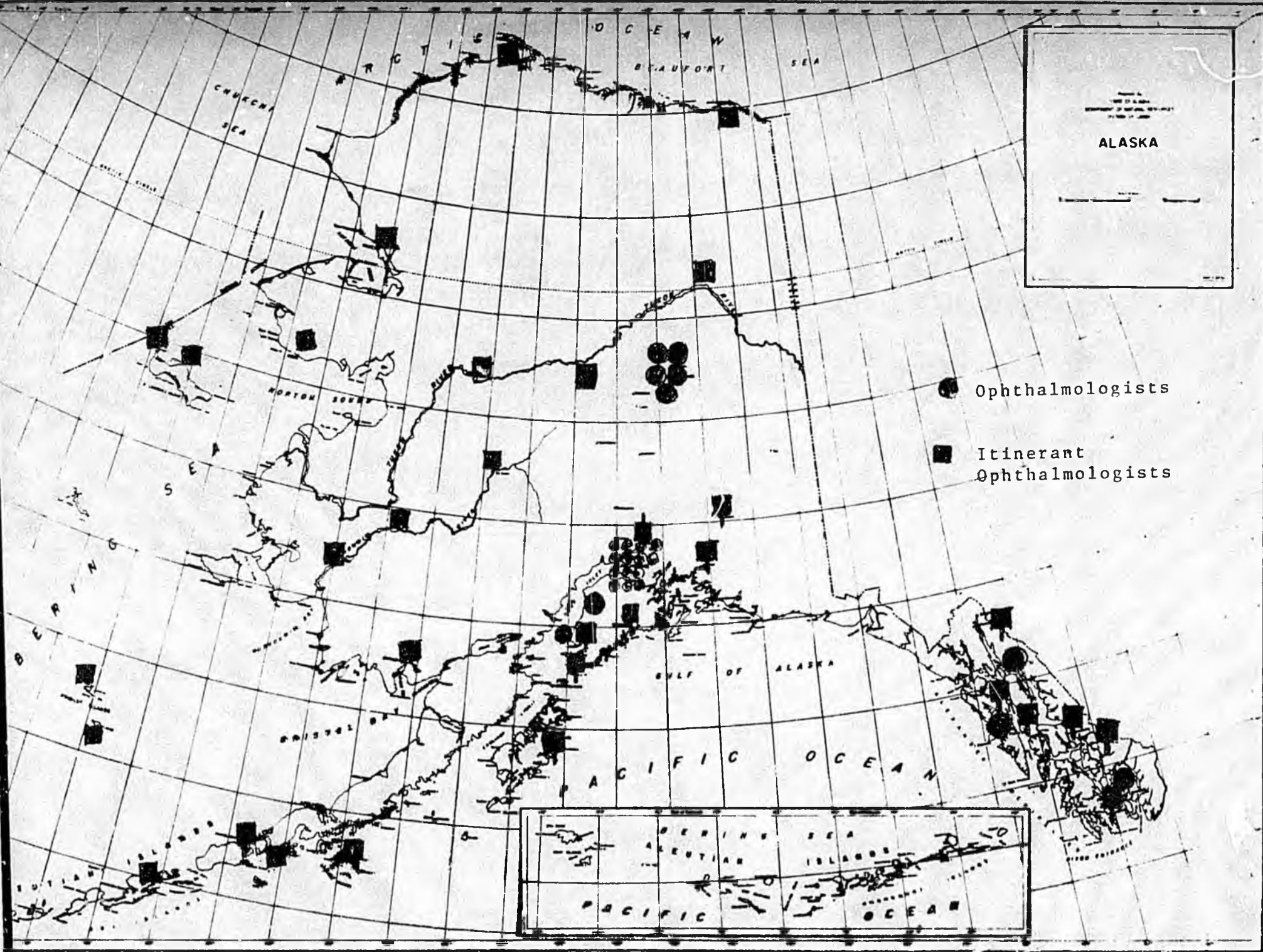
<u>Service</u>	<u>Optometrists</u>	<u>Ophthalmologists</u>
Refraction	99%	99.5%
Ophthalmoscopy	92%	99.5%
Contact Lenses	79%	58%
Visual Fields	75%	94%
Tonometry	66%	99.5%
Orthoptics	50%	53%
Low-vision aids	40%	55%
Biomicroscopy	32%	99.5%
Aniseikonic Testing	8%	9%
Treatment of eye disease	1-2%	100%
West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

TABLE 3

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

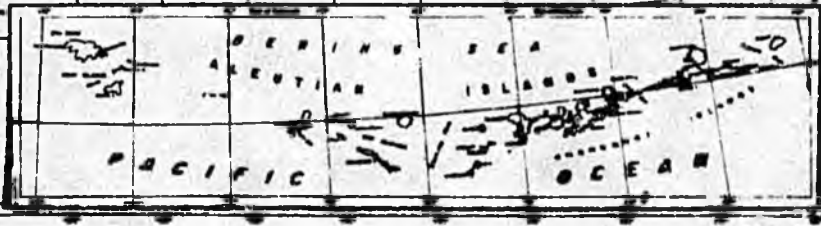
<u>A. Expenditures</u>	<u>OFFICES OF OPTOMETRISTS</u>	<u>OFFICES OF OPHTHALMOLOGISTS</u>
General examinations	\$525	\$510
Medical treatment and therapy	40	500
Ophthalmic Services:		
Corrective Eye glass Lenses	865(49.6%)	180(14%)
Contact Lenses	285	60
Other	<u>30</u>	<u>        </u>
	1,745	1,250
		No optical shops No surgery

Bureau of  
 Health, Education & Welfare  
 Department of Health, Education & Welfare  
 1968 O-300-001  
**ALASKA**  
 1:500,000  
 1968 O-300-001



● Ophthalmologists

■ Itinerant Ophthalmologists





**\*\*PLEASE NOTE\*\***

THE ORIGINAL FILE CONTAINS AN OVERSIZED DOCUMENT THAT IS UNSUITABLE FOR FILMING. PLEASE REFER TO THE ALASKA STATE ARCHIVES TO VIEW THE ORIGINAL.

DESCRIPTION:

TWO TABLOIDS "THE PEN , PUBLISHED IN THE PUBLIC INTEREST BY OPHTHALMOLOGY"

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VOLUME 3, NUMBER 17, DECEMBER 1, 1979

VOLUME 3, NUMBER 1, DECEMBER 15, 1978 - JANUARY 1, 1979

HB

85

# COMMITTEE REPORT

## HOUSE

FURTHER:

January 26, 1979

Date: \_\_\_\_\_

Mr. Speaker:

The Committee on JUDICIARY has had HB 85

"An Act relating to bar examination review procedures; and amending Alaska Bar Rule 7, Section 1."

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

- do pass  do not pass
- do pass with attached amendments(s)
- replace with CS for HB 85  same title  
 new title
- and recommends Do Pass
- AND attaches a "Letter of Intent"  New Fiscal Note
- reports it back without recommendation
- referred to the \_\_\_\_\_ Committee

**MEMBERS SIGNING  
DO PASS**

Russell D. Pass

Terry Martin

W. Bennett

Patrick O'Connell

James Anderson

Y. D. Anderson

Charles

John

Thomas

**MEMBERS HAVING  
OTHER RECOMMENDATIONS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

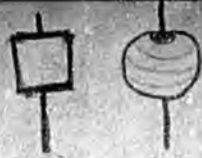
\_\_\_\_\_

\_\_\_\_\_

Charles

CHAIRMAN

HB 85  
2/5/79



Bar Assn view:

appeal only on procedures, not on substance  
how many examiners score test? at least two, 3<sup>rd</sup>  
if disparity between first two

Norm Gorsuch -

Exam 3 parts

1. Calif part, essays (factual situations)
2. Ak " " " "
3. Multi-state part - short para, multiple choice

graded by prof. graders in Calif, use analysis giving main issues -

essays created in Ak, graders analysis

65-70 score, exams re-read, re-graded  
(Ak examiners read Calif portion too)

Kevin McCarthy - lie in RI, Mass, DC  
don't automatically review Ak portion -

Fred -

unconstitutional

2/17/79

Norm G.

1053 took exam, 75% passed  
23 petitioned for hearing, 13 got it  
40% multi state, 40% California, 20% Ak essay

Rick Helm

43 jurisdictions use multistate bar exam (1978 ed)

Bar Rozell - applicants get: own answers  
analyses  
several other papers  
Supreme Court Order #541 modifies Rule 7

90-100 - 22	40-50 - 12
80-90 - 35	30-40 - 9
70-80 - 32	20-30 - 13
60-70 - 15	10-20 - 6
50-60 - 9	0-10 - 2

HB 85

Kevin Jones - 1973 - came here  
cum laude - undergraduate  
Law School  
3 years practical legal experience

doesn't know what to study  
doesn't understand how it's graded

Oregon - Bar -

Oregonian  
Fri Jan. 26  
1979  
Revamping of  
Bar

1. eliminate multiple choice
2. allow internship (15-10)
3. # of subjects reduced
4. process of review of exam
5. out of state (eliminating residency)

he asked for a review - (if merited)  
first need to show discrepancy  
before a review is warranted

can only take 3 times without  
special permission -

a hearing doesn't necessarily tell  
how far where you goofed up

HOUSE JUDICIARY COMMITTEE MINUTES

February 5, 1979

CHAIRMAN PARR called the meeting to order at 3:10 with all members present but Representative Malone who entered later.

The subject of the meeting was House Bill 85, An Act relating to barexamination review procedures; and amending Alaska Bar Rule 7. The Chair opens the meeting to testimony.

REPRESENTATIVE JOE MCKINNON testified as prime sponsor of the bill. He introduced the bill at the request of an Anchorage person who twice failed the bar exam and felt that the lack of a right to appeal was unjustifiable. Under the present system, a examinee can review his exam and some other exams. When this person did this he found great discrepancy between his score and the score of another exam which answered the same question virtually the same. McKinnon believes the guidelines for examiners are too general and that the bar exam should primarily cover a persons competency in law, more like any other type of occupational liscensing. He believes there should be model answers to essay questions that cover the basic competency of the question.

Representative BROWN asked McKinnon if he realized any constitutional problems with the bill during drafting, to which McKinnon replied that drafter Dick Bradley thought there possibly could be Constitutional problems. Other questions from the committee members included problems with the tests and test graders being from California, questions of statistics of persons passing/failing the exam and how close the 5 points is to passing.

NORM GORSUCH appeared on behalf of the Alaska Bar Association. He explained that some of the Bar Association people who could give valid testimony were unable to be here for one reason or another. He explained the new Bar Rule 7 to the members and the procedures for examination and grading as they now exist:

C. KEVIN MCCARTHY appeared on behalf of himself in support of the legislation having experienced similar problems as MCKINNON'S constituent.

Representative FRED BROWN testified on behalf of himself. He expresses a strong belief that the legislature has no jurisdiction over Court Rules under the state's Constitution

After continued discussion on the same lines Chairman PARR suggests to the committee that they hold the bill for a few days pending further testimony from the American Bar Association.

Meeting adjourned at 4:50p.m.



# Alaska State Legislature

## House of Representatives

### Committee on Judiciary

Official Business

Pouch V  
State Capitol  
Juneau, Alaska 99801

TO: House Judiciary Committee Members  
FROM: *Lucky* Rocky Plotnick, Committee Assistant  
DATE: February 5, 1979  
SUBJECT: HB 85

I just talked with Kevin Jones in Anchorage and he wanted me to pass some information along to the Committee regarding HB 85. Mr. Jones is a law school graduate and has had three years practical legal experience in Alaska. He has taken the Alaska Bar Exam twice and failed it twice. His comments are:

1. When taking the Alaska Bar Exam a person does not know what to study or how the exam is graded.
2. A review is granted (of the exam) only if it is warranted. A discrepancy must first be shown.
3. The Alaska Bar Exam can be taken three times. Special permission is required after that.
4. The State of Oregon has been reviewing its bar admittance procedure and has come up with the following recommendations:
  - a. elimination of the multiple choice section
  - b. allow internships in place of an exam with proper endorsement
  - c. reduce the number of subjects covered from 15 to 10
  - d. establish a review process of the exam.

HOUSE BILL 85

1. Passing percentage for the last five years:

	# of Applicants	% of Passing Applicants
February, 1973	43	67
July, 1973	52	71
February, 1974	44	90
July, 1974	83	83
February, 1975	69	79
July, 1975	82	69
February, 1976	96	76
July, 1976	97	79
February, 1977	108	76
July, 1977	124	78
February, 1978	100	65
July, 1978	125	72
	<u>1023</u>	75.42% (average percent)

2. Number of failures (five year period) - 252 <sup>64 = 25%</sup>

3. How many repeated and passed?

From the information I researched, approximately 64 repeated and passed.

4. How many failures petitioned for a hearing?

Again, from that research, it appears 23 petitioned for a hearing.

5. How many failures were granted a hearing by the Board of Governors?

Records indicate 13 people were granted a hearing.

6. What are procedures on granted hearings?

If there appears to be grounds, the Board appoints a Master to investigate.

Kevin McCarthy  
Dept. Revenue

Chairman Parr  
Committee on Judiciary  
Alaska House of Representatives

Dear Representative Parr,

Once again, I want to thank you and the other members of the Judiciary Committee for allowing me to testify on HB 85, the proposed change in Alaska Bar Rule 7.

What HB 85 proposes is not a radical intrusion on the part of your committee into the internal affairs of the Bar Association. It is rather, a recognition on your part, that the Bar Association does not presently comply with the spirit of Alaska Bar Rule 7, in that it arbitrarily rejects requests for a hearing, even when those requests are founded on questions of law and statutory interpretation, as mine was, and not merely on disagreement over assigned grades.

HB 85 would alleviate that problem by establishing a set standard applicable to all candidates. To my way of thinking, establishing uniform standards and removing discretion, especially in view of the fact that the Bar Association evidently exercises its judgement in bad faith, is more constitutional, and not less constitutional. HB 85 removes a constitutional defect in the Rule, by guaranteeing due process and equal protection to all candidates, and not merely the select few whom the Board of Governors favors with a hearing.

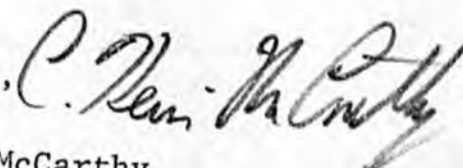
A In my case, I filed the attached Statement of Appeals and First amended Statement of Appeal on November 20 and 21, 1978, within the period prescribed by Alaska Bar Rule 7 sec. 1.

On December 18, I received the second attachment, a letter from Ken Jarvi, President of the Alaska Bar Association, informing me that the Board of Governors had reviewed my Statement of Appeal and found it to be insufficient to warrant a hearing. His answers to several of my points of appeal were not responsive, and I still believe there are questions of fact and law at issue which would warrant a hearing.

Had I been granted a hearing, then I would have been given Findings of Fact, Conclusions of Law, and a Decision, pursuant to Alaska Bar Rule 7 sec. 12, and I could've appealed the decision pursuant to Alaska Bar Rule 8. I have bona fide arguments to make, but, very possibly, no forum to make them in. I am preparing to ask the Supreme Court of Alaska to hear my petition, but the question of whether they will sit as a court of original jurisdiction, instead of just reviewing a record from below, is not clear.

I am in a state of legal limbo, or as Representative Brown aptly phrased it a "Catch 22 situation". My rights would be clear if HB 85 were law, and I urge you to enact it.

Sincerely,

  
C. Kevin McCarthy

In the matter of the application of )  
C. KEVIN McCARTHY )  
For admission to the Practice of Law ) Statement of Appeal  
in Alaska and membership in the )  
Alaska Bar Association )

Petitioner C. Kevin McCarthy hereby requests a hearing on the failure of the Board to certify him to the Supreme Court of Alaska for admission to the Alaska Bar Association, pursuant to Alaska Bar Rules Rule 7, section 1

Petitioner relies on the following grounds, severally and cumulatively.

1. Petitioner did not fail to receive a score of 70% of the highest possible grade on the July 1978 Alaska Bar exam. Petitioner's score of 69.6% is in fact 70% of the highest possible grade and petitioner alleges an abuse of discretion on the part of the Committee of Law Examiners in not rounding his score off to 70

2. Petitioner states that neither the Committee of Law Examiners, the Board of Governors of the Alaska Bar Association, nor any of its officers have ever promulgated written standards for determining exact examination scores. Petitioner further states that given the great importance of the subjective judgements that the Committee of Law Examiners must make, and the tolerance or margin of error which must be contemplated and allowed for when human subjectivity is exercised, that this failure to promulgate written standards amounts to a denial of substantive due process and an abuse of discretion by the Board of Governors.

3. Petitioner states, and will prove to a mathematical certainty, that while the Committee of Law Examiners has credited him with a score of 69.6, that he in fact should have been credited with a score of 69.7, and this demonstrates how the lack of precise grading regulations can and did harm petitioner and operate as an abuse of discretion.

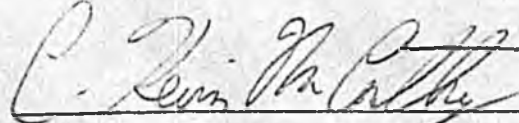
4. Petitioner further states that the Committee of Law Examiners recognizes the uncertainty and arbitrariness of essay grading and in fact conducts a review of the California essays for that reason. Petitioner states that the Committee's failure to conduct a similar review of the Alaska essays is an abuse of discretion.

5. Petitioner states that the Alaska Bar Association Rule 4, section 6 is an unfair rule in that it fails to take into consideration the changing level of difficulty of the Multistate Bar Exam, and sets a standard of 135 as a score of 70% rather than selecting whatever scaled score from that particular administration of the test corresponds to the desired level of achievement for a score of 70%. Petitioner further states that this operates as a denial of equal protection to that group of candidates who compose the class of candidates who substitute an MBE score obtained in a prior administration of the MBE exam, and that this results in an abuse of discretion.

6. Petitioner states that on either October 26, 1978 or October 27, 1978, 23 days ago, he did request in writing, pursuant to Alaska Bar Rule 4, section 5, to review his exam books and the representative sampling of passing and failing answers to the bar examination in Bethel, Alaska, as soon as possible. Petitioner further states that Bethel is presently home to 1 Superior Court House and Judge and nine

C. Kevin McCarthy  
AVCP  
Box 219  
Bethel, AK 99559  
(907) 543-3521

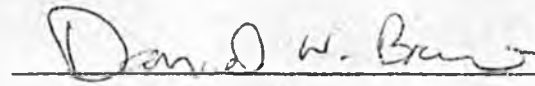
other attorneys who are members in good standing of the Alaska Bar Association, anyone of whom could serve ably as proctors during his review of the exam books. Petitioner alleges that the Alaska Bar Associations failure to respond to his request is further abuse of discretion, in that it has unreasonably deprived him of the timely opportunity to review his exam that all residents of Anchorage, Fairbanks, Juneau and other urban areas of the state have.



C. Kevin McCarthy, Petitioner

DATED: \_\_\_\_\_

11-20-78



Notary Public

C. Kevin McCarthy  
AVCP  
Box 219  
Bethel, AK 99559  
(907) 543-3521

In the matter of the application of )  
C. Kevin McCarthy )  
For admission to the Practice of Law )  
in Alaska and membership in the )  
Alaska Bar Association )

Statement of Appeal  
First Amended

Petitioner C. Kevin McCarthy, stating that the time period for filing a Statement of Appeal has not passed, makes the following amendment to his Statement of Appeal of November 20, 1978.

Grounds 1 thru 6 inclusive are hereby incorporated by reference to this Statement.

7. Petitioner states that the Alaska Essay section of the July 1978 Alaska Bar Exam is not truly representative of an exam on the law of Alaska, in that it fails to question candidates on their knowledge of truly Alaskan legal principles of the Limited Entry Fishing Laws, Alaska Native Claims Settlement Act, Native Land Claim Allotments, Public Land Laws, and the Revenue Laws of the State of Alaska pertaining to Oil and Gas Severance and Income Taxes. Petitioner further states that if the Committee of Law Examiners were to truly examine a candidate on his knowledge of the law of Alaska, they would include mandatory or optional questions on some or all of these subjects. Petitioner further states that attorneys, such as himself, who have immersed themselves in the knowledge of these subjects, which form the backbone of the unique cultural, commercial, and financial jurisprudence of this state, are disadvantaged by the Committee's failure to do so and that failure constitutes an abuse of discretion on the part of the Committee of Law Examiners.



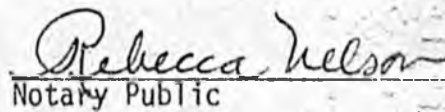
C. Kevin McCarthy, Petitioner

C. Kevin McCarthy  
AVCP  
Box 219  
Bethel, AK  
(907) 543-3521

99559

DATED: \_\_\_\_\_

11-21-78



Rebecca Nelson

Notary Public

My Commission Expires  
April 2, 1979

ATTACHMENT # 2

BOARD OF GOVERNORS

ALASKA BAR ASSOCIATION

OFFICERS  
KENNETH O. JARVI  
PRESIDENT  
ANCHORAGE  
DONNA C. WILLARD  
PRESIDENT ELECT  
ANCHORAGE  
ALBERT H. BRANSON  
VICE PRESIDENT  
ANCHORAGE  
RICHARD D. SAVELL  
SECRETARY  
FAIRBANKS

P. O. BOX 279  
ANCHORAGE, ALASKA 99510  
AREA CODE 907/272-7469

RONALD L. KULL, EXECUTIVE DIRECTOR  
WILLIAM GARRISON, BAR COUNSEL

BOARD MEMBERS  
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STANLEY T. FISCHER  
KAREN L. HUNT  
KENNETH O. JARVI  
EDWARD G. KING  
JONATHAN H. LINK  
WILLIAM B. ROZELL  
RICHARD D. SAVELL  
DONNA C. WILLARD

December 8, 1978

C. Kevin McCarthy  
Box 219  
Bethel, Alaska 99559

RE: Admissions Appeal

Dear Mr. McCarthy:

The Board of Governors on December 3, 1978, reviewed your statement of appeal and the amendments. The appeal is rejected for the following reasons:

1. In reference to your allegation #1 as set forth in your letter of November 20, 1978, it does not appear that you understand the Board's policy regarding the rounding of test scores. Rounding is done at the one-hundredth percentile point not at the tenth decimal point. In other words, in order for your score to be rounded to 70% you would have to have received a 69.95% or better. The score of 69.6% was your final score after rounding.

2. Written standards have been established for determining exact examination scores and have been used consistently in determining the final grade. The scores are exact to the degree that the final scores are carried out to the second decimal point.

3. The score sheet has been reviewed and your final rounded composite score was again determined to be 69.6%. Assuming, for the sake of argument, that you did receive a 69.7% you nevertheless would have failed the exam.

4. The Supreme Court, in In re Butterfield, 581 P. 2d 1109 (Ak. 1978) considered the issue regarding review of the Alaska Essay Portion of the exam and rejected the argument that you advance at number four of your allegations.

## APPLICATION OF BUTTERFIELD

Alaska 1109

CITE AS, Alaska, 541 P.2d 1109

Application of Rhonda F. BUTTERFIELD, for Admission to the Practice of Law in the State of Alaska and Membership in the Alaska Bar Association.

No. 1659.

Supreme Court of Alaska.

July 14, 1978.

An applicant for admission to the Alaska Bar appealed from an order of the Board of Governors of the Alaska Bar Association refusing to regrade the Alaska essay portion of the applicant's Alaska Bar examination. The Supreme Court, Burke, J., held, *inter alia*, that denial of neither due process nor equal protection occurred by virtue of the Board's refusal to regrade the Alaska portions of the examination.

Affirmed.

## 1. Constitutional Law — 230.3(9), 287.2(5)

Neither due process nor equal protection was denied to applicant for admission to Alaska Bar by virtue of refusal of Board of Governors of Bar Association to regrade Alaska portions of applicant's bar examination. State Bar Rules, rules 1, § 3, 4, § 6.

## 2. Attorney and Client — 6

Policy of Board of Governors of Alaska Bar Association not to regrade Alaska essay questions contained in Alaska bar examination did not constitute abuse of discretion

## 1. Rule 23, Alaska R.Civ.P., provides in pertinent part:

(c) *Determination by Order Whether Class Action to Be Maintained—Notice—Judgment—Actions Conducted Partially as Class Actions*

(1) As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be so maintained. An order under this subdivision may be conditional, and may be altered or amended before the decision on the merits.

## 2. Alaska Bar Rule 1, § 3, provides:

The Board shall examine or provide by contract or otherwise for the examination of all applicants for admission to the practice of law and shall determine or approve the time,

on theory that it denied applicants possibility of increase in scores from application of "whole person" concept to their Alaska scores. State Bar Rules, rules 1, § 3, 4, § 6.

Lloyd I. Hoppner, Rice, Hoppner & Hedland, Fairbanks, for appellant.

William W. Garrison, Alaska Bar Ass'n, Anchorage, for appellee.

Before BOOCHEVER, C. J., and RABINOWITZ and BURKE, JJ.

## OPINION

BURKE, Justice.

Rhonda F. Butterfield appeals from an order of the Board of Governors of the Alaska Bar Association ("the Board") refusing to regrade the Alaska essay portion of her February, 1977, Alaska Bar Examination. The appeal was filed as a class action but no certification of the class was obtained as required by Rule 23, Alaska R.Civ.P.<sup>1</sup> Therefore, our opinion is limited to consideration of the issues as to Butterfield alone.

## I

Appellant's arguments are comprehensible only if one understands the grading procedures utilized by the Board, which is charged with the responsibility for administering and grading the Alaska Bar Examination.<sup>2</sup> The Alaska Bar Examination con-

place, scope, form and content of all bar examinations. Bar examinations may, in whole or in part, be prepared, administered and graded by or in cooperation with other states or the National Conference of Bar Examiners consistent with standards fixed or approved by the Board acting with the advice of the Committee of Law Examiners. No contract or cooperative agreement for the preparation, administration or grading of a bar examination shall operate to divest the Board of its authority (1) to cause the Committee to review any examination, and (2) independently to determine the eligibility of an applicant to be admitted to the practice of law. The Board or any member thereof may require an applicant to appear before the Board, a committee or a master appointed by

5. Regarding the MBE portion of the exam, answers to the MBE portion are returned to the National Conference of Bar Examiners where they are scored by computer.

In February, 1974, the MBE program developed the use of "scaled scores". A scaled MBE score is a standard score converted from a raw MBE score (number of correct answers) based on the re-use of questions from prior examinations. The scaled score represents the same level of ability of applicants from test to test though the difficulty of the test and the ability of the examinees may vary. The Educational Testing Service will report to each state a raw score and a scaled score for each applicant then the state has the choice of using either score. The Supreme Court of the State of Alaska has determined that a scaled MBE score of 135 is equivalent to 70%.

The purpose of converting scores to a scale is to make reported scores as independent as possible of the particular form of a test an examinee has taken and the composition of the candidate group at a particular administration. A particular scaled score, for example, of 135, is intended to indicate the same level of ability from year to year and from examination to examination. In other words, if an applicant took a second MBE exam, assuming he maintained the same level of ability, his scaled score on the second exam should be the same as that obtained on the first exam even though one test may have been more difficult than the other and the applicants raw score is different in each examination. Since MBE testing and the use of scaled scores ostensibly not only eliminates the subjective element inherent in essay exams but also does away with the variables which occur due to the degree of difficulty which exist between different exams Alaska Bar Rule I-4 Section 7 allows an examinee to transfer his most recent MBE scaled score, taken within one year prior to the Bar exam, from any other state and thereby to be excused from the MBE exam administered in Alaska.

Before computing the combined scores, all MBE scaled scores are adjusted or converted to place them on a common scale with the essay scores. The converted score will be a percentage ranging from one (1) and one-hundred (100) with seventy (70) percent equivalent to an MBE scaled score of one-thirty-five (135). The converted scores can then be added to the essay scores.

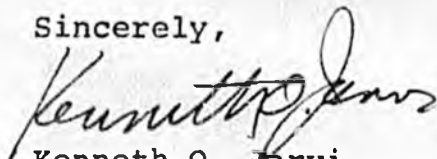
6. Alaska Bar Rule 4 Section 5 states that exam review material shall be available in the Bar office in Anchorage or other places designated by the Board. It is Board policy to send the exam booklets, etc. to a member of the Board of Governors in the area where the applicant resides. In that there is no member of the Board of Governors residing in Bethel the Board determined that Judge Christopher Cook was a suitable person to assume responsibility for the exam items. The material was sent by certified mail to Judge Cook on November 16th. A copy of the letter of transmittal was sent to you on that date also.

C. Kevin McCarthy  
December 8, 1978  
Page - 3

7. The Alaska Supreme Court, in In re Kennelly, 567 P. 2d 301 (Ak. 1977) has ruled that the Alaska Bar Examination need not allow applicants an opportunity to demonstrate their mastery of legal subjects in which they may have a particular interest and knowledge.

The allegations as set forth in the varified statement of appeal are not sufficient to establish abuse of discretion or improper conduct on the part of the Board, the Executive Director or the Committee.

Sincerely,



Kenneth O. Jarvi  
President  
Alaska Bar Association

KOJ/lms

sists of three separate parts: (1) the Multi-State Bar Examination which constitutes two-fifths of the examination; (2) California Bar Examination essay questions which make up another two-fifths of the examination; and (3) essay questions concerning Alaska law which account for the remaining one-fifth of the examination. An overall score of 70% is required to pass the examination. Alaska Bar Rule 4, § 6.

The California portion of the examination is sent to California where the answers to each question are graded by one person. In contrast, the answers to each of the Alaska essay questions are graded, in Alaska, by two graders. If there is a significant disparity between the grades assigned to an Alaska essay, a third grader reviews the essay to resolve the difference. Pursuant to Regulation 8 of the Regulations Concerning Grading of Examinations,<sup>3</sup> the California essays of those receiving an overall score of 65-70% are regraded by Alaska graders. The Board has no similar regrading procedure for the Alaska essays.

Butterfield received an overall score of 68.9% upon the first grading of her examination. Upon the regrading of her answers to the California essay questions, as provided by Regulation 8, her overall score increased to 69.6%, still a failing score. In spite of the Board's policy not to regrade the Alaska essays, Butterfield petitioned the Board requesting that that portion of her examination also be regraded. In her petition she alleged that the Board's policy of not regrading the Alaska essays was arbitrary and an abuse of the Board's discretion. She further alleged that the Board's policy denied her due process and equal protection of the law. The Board

the President for such purpose, at such times and places as may be required, for oral examination and to furnish any such supplemental information or evidence in such form as may be required.

3. Alaska Bar Regulation 8 provides:

Scores received on the California essay portion of the examination will be reappraised by the graders

if the applicant's weighted combined score (total essay plus MBE) falls between 65 and 70 percent; or

denied her petition to regrade the Alaska essays. By this appeal, appellant seeks an order that her February, 1977, Alaska essays be regraded.

## II

[1] Butterfield contends that the Board's refusal to regrade the Alaska portions of her examination denied her due process and the equal protection of the law. Because appellant's rationale for each of these arguments is identical, the two issues will be treated together.

The question presented by appellant's equal protection argument is whether the Board's policy by which those with an overall examination score between 65 and 70 receive a regrading of their California examination questions but not of their Alaska questions, bears a fair and substantial relation to the purpose of examining applicants, when the means used and the reasons advanced therefore are closely scrutinized. *Isakson v. Rickey*, 550 P.2d 359 (Alaska 1976).

For the due process clause to apply there must be "state action and the deprivation of an individual interest of sufficient importance to warrant constitutional protection." *Nichols v. Eckert*, 504 P.2d 1359, 1362 (Alaska 1973). Butterfield argues that the pursuit of a career in law is an interest worthy of constitutional protection and that the action of the Board constitutes state action. Appellant concludes her due process argument asserting that the Board's policy of reappraising the California essays and not the Alaska essays denies her due process of law because it bears no rational connection

if the applicant's weighted total essay score is 65 or greater.

Two graders will be assigned to each borderline applicant to reappraise the California essay examinations. Each grader will assign one grade for all answers. The two grades will be averaged to determine a final reappraisal score that will then be weighted and averaged with the Alaska essay and MBE scores.

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to determining minimal competence to practice law.<sup>4</sup>

In support of her position that the Board's policy satisfies neither the equal protection test of *Isakson v. Rickey, supra*, nor the requirements of due process, Butterfield contends that the sole reason for regrading the California essays is a sense of mistrust of the California graders. She argues that such mistrust is without support or foundation; that a vague sense of mistrust is insufficient justification for treating the California exam questions differently from the Alaska questions; and that therefore the Board's policy of regrading only the California exams is arbitrary.<sup>5</sup>

Appellant concludes her argument for finding the Board's policy violative of equal protection and due process requirements by asserting that the Board's policy appears to be particularly arbitrary in light of the Board's position in *Application of Kennelly*, 567 P.2d 301 (Alaska 1977). In *Kennelly* we concluded that by contracting with California for the supply of California questions and the grading of the California essays, the Board had not violated the rule<sup>6</sup> requiring that it retain authority over testing. We agreed with the Board that it was within its discretion "to take advantage of the . . . expertise and experience available to the California bar examiners . . ." *Id.* at 303. Butterfield contends that the Board's mistrust of California graders contradicts the Board's assertion of reliance on their expertise as set forth in *Kennelly*. She points to this alleged contradiction as support for her argument that the Board's policy is arbitrary.

We find no merit in appellant's arguments. The only support Butterfield sets forth for her argument that the regrading of the California essays is conducted out of a sense of mistrust is a quotation from the deposition of one of the Alaska graders of

the bar exam. The quotation upon which appellant relies is taken out of context and reading the quotation as a whole, it is clear that appellant's interpretation is untenable. The quote in no way suggests that the Board mistrusts the California graders.

Similarly appellant's contention that the regrading procedure contradicts the Board's position in *Kennelly* does not survive scrutiny. As we noted in *Kennelly*, the Board is given broad discretion to conduct and grade the bar examination. The Board does not regrade all of the California essays. It regrades only those of applicants receiving an initial overall score of 65-70%. Appellant has not challenged that classification nor does she suggest that the members within that group are treated differently. The Board continues to rely on the expertise of the California graders for the grading of those exams with scores of less than 65% and more than 70%.

We think it entirely reasonable for the Board to have a reappraisal policy of the California essays for those candidates on the borderline of passing in light of the fact that without reappraisal, the California essays would be graded by only one grader. This double-check ensures that a single California grader does not assess a candidate's essays too harshly. It seems reasonable to assume that such an occurrence would have a significant effect only in the case of candidates on the borderline so that a review of the California essays of those in the borderline group is entirely justified. The same danger does not exist as to the Alaska questions because they are reviewed initially by at least two graders.

Because we conclude that the Board's policy is a reasonable grading procedure and consistent with the Board's broad grant of authority to examine and grade applicants for admission to the Alaska Bar, we hold that appellant was not denied due

4. Butterfield does not contend that she was denied procedural due process as required by *Application of Peterson*, 459 P.2d 703 (Alaska 1969), as she pursued her *Peterson* remedies including the opportunity to compare her exam with model answers.

5. Appellant does not suggest, however, that the Board discontinue regrading the California essays of the applicants with scores of 65-70% in order to achieve consistency.

6. See note 2, *supra*.

process of law. Similarly we conclude that the Board's policy satisfies the requirements of equal protection as enunciated in *Isakson*.<sup>7</sup>

[2] Appellant premises her final challenge to the Board's regrading policy on a slightly different aspect of the regrading procedure. Upon regrading the California essays, the Alaska graders may apply what is called the "whole person" concept. The "whole person" concept comes into play if the grader, upon totalling the separate California essay scores, feels that the number does not accurately represent the applicant's performance on the California essays. Under those circumstances the grader, in his or her discretion, may increase the score of the applicant.

Butterfield contends that the policy of not regrading Alaska essay questions denies applicants the possibility of an increase from the application of the "whole person" concept to their Alaska scores. She concludes that the denial of this possibility is an abuse of discretion.<sup>8</sup>

We are unconvinced by appellant's argument. As we noted previously, the grant of authority given the Board to conduct and grade the bar exams is broad. A certain amount of flexibility is required in order for the graders to assess fairly the performance of applicants. The occasional application of the "whole person" theory appears to be well within the sort of flexibility required to perform the grading task fairly. We cannot agree with appellant that the occasional application of this theory to the California essays and the refusal to apply it to the Alaska essays rises to the level of an abuse of discretion.

AFFIRMED.

CONNOR and MATHEWS, JJ., not participating.

7. Our conclusion that the circumstances in this case satisfy both the equal protection and the due process tests is not meant to suggest that in all cases the tests are co-extensive.

NORTH SLOPE BOROUGH, Appellant,

v.

Robert LeRESCHÉ, Commissioner of Alaska Department of Natural Resources, Michael C. T. Smith, Director, Division of Lands, Alaska Department of Natural Resources and the State of Alaska, Appellees.

No. 3275.

Supreme Court of Alaska.

Aug. 4, 1978.

Borough appealed from the Commissioner of Natural Resources' rejection of its application to select state lands overlaying the Prudhoe Bay oil field. The Superior Court, Third Judicial District, Eben H. Lewis, J., rendered judgment for the Commissioner and borough appealed. The Supreme Court, Matthews, J., held that: (1) the Commissioner had the authority to reject the selection application on the grounds that it was inconsistent with the best interests of the state, and (2) the Commissioner did not abuse his discretion in rejecting the selections made by the borough.

Affirmed.

1. Public Lands ⇔ 142%

State Commissioner of Natural Resources had authority to reject borough selection application on ground that it was inconsistent with best interests of state. AS 29.18.190.

2. Public Lands ⇔ 142%

When state rejects selection application as contrary to best interests of state, it

8. The graders do not have information as to the names of those taking the examination, and it is not contended that the selection of applicants for application of the "whole person" concept is made on an arbitrary basis dependent upon the identity of the examinee.

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THE SUPREME COURT OF THE STATE OF ALASKA

ORDER NO. 341

Amending Alaska Bar Rules  
7 and 8, Relating to  
Admissions and Adding a  
New Section, 7.1.

IT IS ORDERED:

1. Sections 6, 7, 8, 9, 10, 11, and 12 of Rule 7, Alaska Bar Rules, are deleted and a new section 6 is added to read:

Section 6. Only the following materials shall be subject to production by the Alaska Bar Association in any proceedings held pursuant to this Rule:

(a) Where certification for admission to practice has been denied, the failing applicant has the right to inspect his examination books, the grades assigned thereto, the examination questions, the graders' analyses of the questions and a representative sampling of passing and failing answers to the bar examination at the office of the Alaska Bar Association or at such other place and such time or times as the Board may designate;

(b) Where an examination permit has been denied because of failure to meet residency requirements, the applicant has a right to inspect the minutes of any meeting of the Board of Governors at which his application has been discussed, together with a synopsis of the facts with respect to any other person who, within the last two years, has been denied an examination permit for the same reason; and

(c) Where an examination permit has been denied on the basis of character, the applicant has a right to inspect the minutes of any meeting of the Board of Governors at which his application has been discussed, together with a statement of the

specific grounds upon which denial of the permit was based.

2. The Alaska Bar Rules are amended by adding a new section, 7.1, to read:

Rule 7.1. Procedures.

Section 1. All hearings before the master shall be electronically recorded with facilities provided by the Alaska Court System. The transcript of testimony and exhibits, together with all papers and requests filed in the proceedings, shall constitute the exclusive record for decision. The record may be destroyed two years following the last date upon which administrative appeal rights may be available under the provisions of this rule.

Section 2. From the time he has been designated to preside until issuance of his proposed decision and the transfer of the proceeding to the Board, the master shall have the following authority to:

- (a) take or cause depositions to be taken;
- (b) require the filing of memoranda of law and the presentation of oral argument with respect to any question of law upon which a ruling will be required;
- (c) hold conferences for the settlement or simplification of the issues by consent of the parties;
- (d) dispose of procedural requests;
- (e) establish the time limitations for the filing of pleadings and set the times for any hearings;
- (f) preside at and regulate the course of the hearing, maintain decorum, and exclude from the hearing any person engaged in contentious conduct or otherwise disrupting the proceedings;
- (g) administer oaths and affirmations;