ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1476 SHESS SB 136 (#1 - #2)

1476

PROPOSED DRAFT COMMITTEE SUBSTITUTE FOR SENATE BILL 136 - OPTOMETRY
by the Senate HESS Committee - March 28, 1981

* Section 1. AS 08.72.020 is amended to read:

Sec. 08.72.020. Membership of board and terms of office. The board consists of six (FIVE) persons, appointed by the governor. Members serve staggered terms of four years.

* Section 2. AS 08.72.040 is amended to read:

Sec. 08.72.040. Qualifications. Four board members shall be licensed, practicing optometrists who have been residents for at least three years. One board member shall be a public member with no interest, direct or indirect, in the practices of optometry, opticianry or medicine. One board member shall be a licensed physician pursuant to AS 08.64.170. - AS 08.64.350. A person who has served two successive complete terms may not be reappointed until four years from the expiration of the second term that he served.

* Section 3.AS 08.72.060(c) is amended to read:

(c) The board shall

(1) elect a president and secretary from among its members;

(2) order a licensee to submit to a reasonable physical examination if his physical capacity to practice safely is at issue.

(3) establish specific diagnostic drugs and the strengths thereof within the limits of AS 08.72.300(7), with the advice and guidance of the state medical board.

* Section 4.AS 08.72 is amended by adding a new section to read:

Sec. 08.72.272. Use of "Dr." or "Doctor". When an optometrist uses the title "Dr." or "Doctor" as a prefix to his name, without using the word "optometrist" as a suffix to his name or in connection with it, it constitutes a cause to revoke or suspend his certificate of registration.

* Sec. 5. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.280. REFERRAL TO OTHER MEDICAL SPECIALISTS. If, during the course of examining a person, an optometrist determines the possibility of the existence of a pathological condition, the optometrist shall so advise the person and shall refer the person to an appropriate medical specialist for further evaluation.

* Section 6. AS 08.72.300(2) is amended to read:

(2) "optometry" is the examination, other than by the use of drugs, <u>except diagnostic drugs as defined in this section,</u> of the human eyes and the visual system for the purpose of ascertaining a departure from the normal, ascertaining the status of the human visual system, including refractive and functional abilities, or ascertaining the presence of ocular disease and any other departure from the normal which requires referral to other health care practitioners; or the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

* Section 7. AS 08.72.300(3) is amended to read:

(3) "practicing optometry" is an examination, other than by the use of drugs, <u>except diagnostic drugs as defined in this section,</u> of the human eyes and visual system for the purpose of ascertaining a departure from the normal, ascertaining the status of the human visual system, including refractive and functional abilities, or ascertaining the presence of ocular disease and any other departure from the normal which requires referral to other health care practitioners; or the diagnosis 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;

* Section 8. As 08.72.300 is amended by adding a new subsection to read:

(7) "diagnostic drug" means a cycloplegic, mydriatic, or topical anesthetic which is listed in the official United States Pharmacopoeia, or official National Formulary, or any other supplement to either of them.

* Section 9. As 08.72. is amended by adding a new section to read:

Sec. 08.72.305. Use of drugs for diagnosis. No optometrist shall be registered or certified to practice optometry in the state of Alaska in any area that is beyond the scope of his educational training as determined by the board of optometry. Any optometrist presently registered in the state of Alaska and who desires to employ the use of diagnostic drugs must submit to the board of optometry evidence of satisfactory completion of all necessary educational requirements as made mandatory by the board. The board of optometry shall provide for continuing educational requirements by all optometrists desiring to employ diagnostic drugs. Diagnostic drugs may be sold, given away, bartered, exchanged, or distributed upon the written order or perscription of an optometrist who is authorized to use diagnostic drugs as provided in this chapter.

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

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

February 23, 1981

The Honorable Charlie Parr
Health, Education and Social
Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr,

This letter is to urge your support of S.B. 136. As an Optometrist in this state, practicing in Anchorage for 15 years, I feel somewhat frustrated. I have been trained to use diagnostic drugs, I am required to find pathology of the eye, for which I was trained, yet the state of Alaska does not permit me the use of diagnostic agents, a tool which is often necessary to detect pathology.

This is a dangerous situation for me, as I can be sued for not detecting pathology. This is a dangerous situation for the patients as he ultimately suffers if pathology of the eye is not detected.

Most states allow Optometrists to use diagnostic pharmaceutical agents, which they were trained to use. Alaska needs to concider the patients welfare. Support S.B. 136.

Respectfully,

Jim Falconer

Jim Falconer, O.D.

cc: Senators
Terry Stimson
Vic Fischer
Tim Kelly
Mike Colletta

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

February 19, 1981

Senator Charlie Parr
Pouch V
Juneau, Alaska 99811

Dear Senator Parr,

I am writing to ask your support for Senate Bill 136.

You may be aware that Optometrists provide the majority of vision care in Alaska. You may not be aware that current laws prevent us from providing the best possible care. The use of diagnostic agents would enable us to provide such care.

Many Alaskans are subjected to needless and costly referrals because Optometrists are prevented from using the proper tools such as diagnostic agents to provide service.

A majority of the states recognize this fact and allow Optometrists to use diagnostic agents.

Alaska should certainly be such a state, due to its vastly dispersed population. Optometrists traveling in the bush areas, are faced with situations where the use of diagnostic agents would prevent a patient having to travel hundreds of miles for a simple condition.

There is no logical reason for Alaska to remain in the dark ages of vision care. The Alaska citizen deserves the best possible vision care, and you are in a position to assure them that they receive it. They can only receive the best care by passage of Senate Bill 136.

Sincerely,

Thomas F. Harbour, O.D.

cc: Terry Stimson
Vic Fischer
Mike Colletta
Tim Kelly

Selby – HB 223 likes
– Raises revenue sharing for hosp ($225,000 to $750,000
– Rural Health Initiative funds to be converted to block grants thru state (Natl Health Svc Corps title)
–

Dept – maybe jointly promulgate –
– McConkey –
– Spence – Dept wants drugs by name rather than defined by regulatory process
– McConkey: Board difficult to judge qual in sec 7. Standards not up to medical standards in Ark.
–

Dr Back – would not allow optometrists to use therapeutic drugs –

Spence – control on dist –
– exam prior to permission to use – specify clinical trng

Tim – req diag drugs by Dept
– exam should be given by Dept –
–

McConkey –

Margie Oglund – Med Bd agreeable to join in promulgation

Dr Back – advice & guidance from Med Bd – drugs

Harry Trager – fiscal note if add member
Dr Page – not water down power of med in

SB

136

2/2

COMMITTEE REPORT

SENATE

2/3/81 FURTHER: Judiciary

Date: ____________________

Mr. President:

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had SB 136

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 ____________________ [ ] same title [ ] new title

and recommends ____________________

[ ] AND attaches a "Letter of Intent" [X] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the ____________________ Committee

MEMBERS SIGNING DO PASS

[signatures]

MEMBERS HAVING OTHER RECOMMENDATIONS:

[signature]

CHAIRMAN

S 60 (Rev. 12/78)

Co promise

FEB 2 5

1. Optometry would be allowed to use proparacaine 0.5% as a topical anesthetic for diagnostic purposes, 1% tropicamide or phenylephrine hydrochloride 2.5% - 5% for dilatation of the pupil for diagnostic purposes.
2. Any changes in this list of medications will be by the combined concurrence of the State Board of Optometry and the State Board of Medical Examiners.
3. A training course will be completed by each optometrist desiring to use drugs prior to any examination. The course shall consist of the following minimum subject matter:
   A. Clinical pharmacology and drug organ interactions.
   B. Cardiopulmonary resuscitation and emergency training.
   C. Techniques of clinical examination.
   D. Thorough review of clinical signs of fundus, anterior segment, and external disease as well as referral guidelines.

Any practitioner optometrist will take a written examination in the above by test committee comprised of two optometrists and two ophthalmologist, each chosen by their respective professional organizations to assess competency in the above.

When an Optometrist examines any person, he shall inform that person, parent, guardian, or other responsible party, prior to prescribing or providing eyeglasses or other services that examination by a licensed physician ~~specializing in disease of the eye (or if no such licensed physician is available then by a duly licensed physician)~~ is indicated whenever one or more of the following conditions is present. ~~These conditions fall generally into four categories where there is:~~

1. An abnormality of vision.
2. An abnormality of tissue.
3. An abnormality of motor function.
4. Other.

unless the cause has been medically determined by a physician and is stable or unless there is improvement within two weeks with visual therapy.

B. A complaint by the individual of a sudden appearance of spots or flashing lights, scintillating images, transient dimming or loss of vision, or distortion in the shape of objects.

C. A complaint by the individual of temporary or permanent loss of any part of the visual field.

D. A history of rainbow halos around lights in the absence of contact lens causes.

E. Diplopia (double vision) of sudden onset.

2. Tissue Abnormalities:

A. Presence of [redacted], swelling, mass or ulceration of the eye or its surrounding tissues in the absence of contact lens causes.

B. Opacities of the cornea, lens or vitreous.

C. Changes in the appearance of the optic discs.

1. Cupping greater than 0.5 cup-disc ratio (C-D).

2. Difference greater than 0.2 C-D ratio between the two eyes, that is .2 C-D one eye and .5 C-D the other eye.

3. Difference in appearance between the optic discs of each eye.

4. Change in appearance of the optic discs from a pervious exam.

5. Suspicion of elevation of the optic nerve head.

D. Observation of a deviation from the normal appearance of the retina or its vessels.

in straight ahead gaze or gaze in any direction. ~~[illegible]~~ to correct of refractive error or exercise.

B. A difference in the size of the pupils or failure to constrict with illumination or with near vision.

C. Ptosis or lag ophthalmus (drooping of the eyelids) with onset within one week of examination.

D. Nystagmus (rapidly oscillating eye movements).

4. OTHER:

A. Continuous tearing of longer than 24 hours duration or complaints of watering eyes not associated with visual tasks.

B. Intraocular tension of 22 or more on any occasion ~~or a family history of glaucoma~~

C. Any other observation or deviation from the usual appearance of the eye and related tissues or any complaint which is not attributable to the refractive state or muscle balance, or which is not amenable to lenses, prisms, or visual training.

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

Failure to comply with the provisions of the Act shall subject the offender to revocation or suspension of his licenses to practice Optometry and this Act shall take effect immediately.

It is completely understood at the outset that there is to be no Grandfather Clause attached to any of the above.

Proposed by the Dept. of Health & Social Services (3)

IN THE SENATE BY HEALTH, EDUCATION, AND SOCIAL SERVICES COMMITTEE

COMMITTEE SUBSTITUTE FOR SENATE BILL NO. 136 (HESS)

IN THE LEGISLATURL OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the practice of optometry, and authorizing the use of ophthalmic drugs by optometrists."

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

* Section 1. AS 08.72.240(3) is amended to read:

(3) advertising professional services in a false or misleading manner, [;] including <u>false representation to the public as something other than an optometrist, which is meant as an optician, eye physician, or by any other designation which would confuse the nature of his licensed practice.</u>

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

Sec. 08.72.280. REFERRAL TO OTHER MEDICAL SPECIALISTS. If, during the course of examining a person, an optometrist determines the possibility of the existence of a pathological condition, the optometrist shall so advise the person and shall refer the person to an appropriate medical specialist for further evaluation.

* Sec. 3. AS 72.300(2) is repealed and reenacted to read:

(2) "optometry" means the employment of any means other than the use of drugs, except the administration

of diagnostic pharmaceutical agents as authorized in AS 08.72.277, medicine or surgery to examine the human eye, to determine the visual efficiency of the human eye, or to determine the powers or defects of vision; the prescribing, providing, furnishing, adapting, using or employing lenses, prisms, contact lenses, visual training, orthoptics, ocular exercise or any other means or device other than the use of drugs, except diagnostic pharmaceutical agents as authorized in AS 08.72.277, medicine or surgery for the aid, relief or correction of vision.

* Sec. 4. AS 08.72.300(3 is repealed and reenacted to read:

(3) "practicing of optometry" means employing any means other than the use of drugs, except the administration of diagnostic pharmaceutical agents as authorized in AS 08.72.277, medicine or surgery to examine the human eye, to determine the visual efficiency of the human eye, or to determine the powers or defects of vision; the prescribing, providing, furnishing, adapting, using or employing lenses, prisms, contact lenses, visual training, orthoptics, ocular exercise or any other means or device other than the use of drugs, except diagnostic pharmaceutical agents as authorized in AS 08.72.277, medicine or surgery for the aid, relief or correction of vision.

* Sec. 5. AS 08.72.300 is amended by adding subsections to read:

(7) "Commissioner" means the Commissioner of the department of Commerce and Economic Development.

(8) "Committee" means the Alaska State Committee on Optometric Drugs established in AS 08.72.277.

* Sec. 6. AS 98.72 is amended by adding a new section to read:

Sec. 08.72.277. USE OF DRUGS. (a) There is created the Alaska State Committee on Optometric Drugs. The Committee shall consist of five members, including one ophthalmologist from a list of nominees recommended by the Alaska State Medical Board, the Director of the State Division of Public Health, one pharmacist recommended by the Alaska Board of Pharmacy, and two optometrists from a list recommended by the Alaska Board of Examiners in Optometry. All members shall be appointed by the commissioner of the department for three year term. The commissioner shall designate the chairperson of the committee who shall remain chairperson throughout his term. All members shall be voting members. If any member shall cease to act for any reason, prior to the termination of his appointed term, the commissioner shall appoint a new member with the same qualifications as the replaced member and to complete the term of the member ceasing to act. The Committee shall meet at the call of the chairperson, ~~but not less than quarterly~~.

(b) The Committee shall have the following rights and responsibilities:

(1) to approve those diagnostic pharmaceutical agents topically applied to be utilized by optometrists in this state, and the strength thereof. The agents shall be limited to cycloplegics, mydriatics, and topical ~~an~~anesthetics;

(2) to approve those optometrists who shall be authorized to use those diagnostic pharmaceutical agents approved by the committee, ~~no~~ No optometrist shall be approved until he has exhibited his qualifications by passing an examination on the pharmacology of ophthalmic drugs prepared or approved by the committee. Such exam shall consist of written questions designed to test knowledge of the proper listed characteristics of the diagnostic pharmaceutical agents approved by the Committee. Approval shall consist of an endorsement by the Committee to his registration certificate authorizing him to use opthalmic drugs and specifying restrictions on their use, if any;

(3) to approve educational standards to be used as prerequisites to authorization to use those diagnostic pharmaceutical agents. Provided, however, that no course or courses in pharmacology shall be approved by the Committee unless (a) taught by an institution having facilities for both the classroom and clinical instruction in pharmacology and which is accredited by a regional or professional accrediting organization that is recognized and approved by the Council on Postsecondary Accreditation or the United States Office of Education and (b) transcript credit for the course of courses is certified to the Committee by the institution as being equivalent in both hours and content to those courses in pharmacology required by the other licensing boards in this Chapter whose licensees or registrants are permitted the use of pharmaceutical agents in the course of their professional practice. Such

educational standards shall cover instruction in cardiopulmonary resuscitation and other first aid techniques.

(c) Standards approved by the Committee and adopted in regulation by the department shall be enforced by the Board of Examiners in Optometry. If the Committee, after evidence presented to the Board, finds that clear, cogent and convincing evidence was presented to the Board, but the Board failed to recommend that authority to use diagnostic pharmaceutical agents be withdrawn, then the Committee may withdraw the authority to use pharmaceutical agents from that optometrist.

* Sec. 7. AS 17.15.010 is amended by adding a new subsection to read:

(b) Notwithstanding (a) of this section, diagnostic ophthalmic drug identified by regulation of the State Committee on Ophthalmic Drugs may be sold, given away, bartered, exchanged, or distributed upon the written order or prescription of an optometrist who is authorized to use the drug as provided in AS 08.72.277.

* Sec. 8. AS 17.15.030 is amended by adding a new subsection to read:

(b) AS 17.15.010 and 17.15.020 do not apply to the sale at wholesale by drug jobbers, drug wholesalers and drug manufacturers, or at retail in a pharmacy by a pharmacist, of an diagnostic opthalmic drug identified by regulation of the Board of Examiners in Optometry to an optometrist who is authorized to use the drug as provided in AS 08.72.277.

FUNDUS of the Human Eye

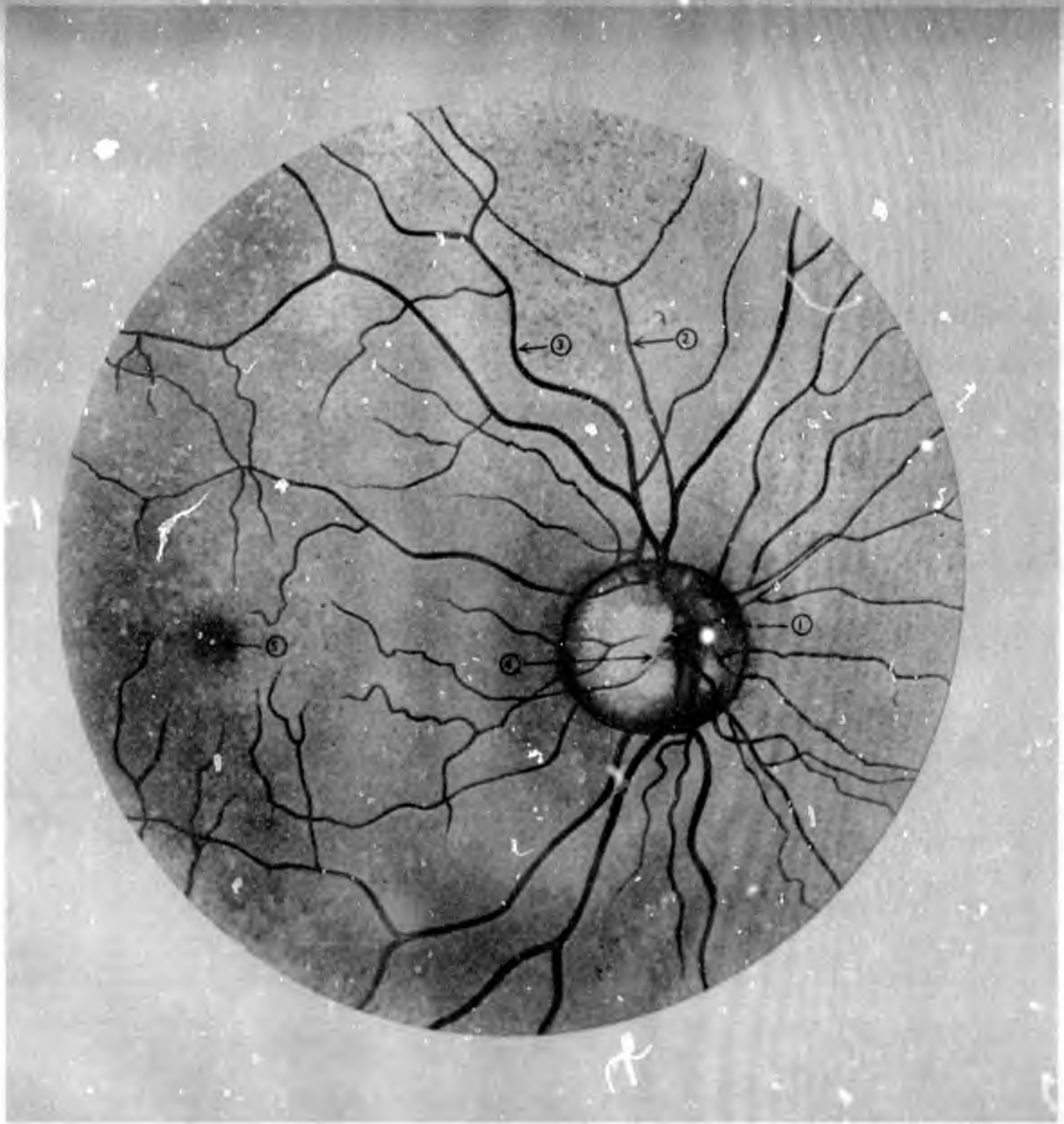
1 OPTIC DISC (NERVE HEAD)
2 ARTERY
3 VEIN
4 PHYSIOLOGICAL CUP
5 MACULA

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

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

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

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



AOA

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

G-10 7/69

COURSE DESCRIPTIONS

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

PROFESSIONAL CURRICULUM

First Professional Year

FALL QUARTER

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

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

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

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

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

WINTER QUARTER

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

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

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

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

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

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

SPRING QUARTER

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

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

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

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

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

Second Professional Year

FALL QUARTER

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

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

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

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

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

WINTER QUARTER

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

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

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

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

SPRING QUARTER

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

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

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

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

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

Third Professional Year

SUMMER QUARTER

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

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

FALL QUARTER

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

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

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

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

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

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

WINTER QUARTER

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

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

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

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

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

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

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

SPRING QUARTER

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

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

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

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

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

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

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

Fourth Professional Year

SUMMER QUARTER

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

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

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

FALL QUARTER

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

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

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

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

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

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

WINTER QUARTER

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

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

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

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

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

SPRING QUARTER

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

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

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

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

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

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

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

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

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

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

Ms. Jerri Beck
UAB Office of Public Affairs

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

Equal Opportunities in Education and Employment

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

The University of Alabama in Birmingham

SCHOOL OF OPTOMETRY

Bulletin

Catalog Issue 1977-78

University Station
Birmingham, Alabama 35294

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

Telephone {456-4010
{452-3232

Dear Representative Parr,

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

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

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

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

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

Very truly yours,

Curtis M. Johnson, O.D.

Copies members
SB 136

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

March 6, 1981

The Honorable Charles H. Parr
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

re: SB 136

Dear Senator Parr:

Thank you for sending me for comment, the compromise proposed by the ophthalmologists. We are willing to make reasonable compromises, and several features of this proposal are acceptable to us.

Here is our response to specific points. I have numbered some paragraphs for reference, corresponding to the numbers below.

1. (Drugs allowed)

The two drugs allowed are a tiny fraction of what the schools prepare undergraduates and existing practitioners to use. Specifying individual drugs in the statute creates an obsolescence problem. We can accept a compromise that specifies certain classes of diagnostic and therapeutic drugs in the statute. We can also accept mandated ophthalmological consultation in determining, by regulation, which drugs within each class may or may not be used. (I would suggest that since this is a detail of implementation, the statute would be less cluttered if the mandate is placed in a letter of intent to accompany the legislation, if this is appropriate for a letter of intent. The Board would follow the directives of the letter of intent.)

2. (Approval of changes in medications by joint concurrence of Optometry and Medical boards)

The Medical Board has opposed drug usage by optometrists in the past. Their involvement would create a 1 to 1 tie, and no change could be made. This is like sending the fox to guard the hen house.

3. (Required training)

Acceptable. One note on cardiopulmonary resuscitation and emergency training: This is taught by many optometry schools even though practitioners are unlikely ever to need it in their practices. I think it is a good thing for every citizen to know. However, graduates who have not had the training should have the

option of taking it in Alaska, such as a Red Cross approved CPR course.

4. (Examination by committee of 2 optometrists and 2 ophthalmologists)

A better system already exists: the schools test the students in their courses. Then the applicant must pass the Board of Examiners in Optometry examination. The Alaska board would use the pharmacology section of the National Boards, an excellent examination constructed from test questions submitted by faculty members of the schools and colleges of optometry, including pharmacologists and ophthalmologists.

5. (Mandatory referral based on single signs and symptoms)

Optometrists in Alaska make literally hundreds of referrals to ophthalmologists and other health care practitioners each year. But this proposal would result in many times that number in needless referrals. Here are some examples:

1A (Less than 20/30 vision for children under 8) - such lower acuity is the norm for preschoolers. Slataper (1950) found the average 5 year old to have 20/32 visual acuity. Weymouth (1963) found 10% of 6 year olds to have 20/36 or less. (Citations available on request). Where visual reduction is due to amblyopia, visual therapy, usually patching, takes up to 3 months or longer to show improvement, not 2 weeks.

1B Spots (floaters) in front of the eyes are normal but often are noticed suddenly, especially by people over 40. They may be pathological (as in uveitis) but this requires corroboration by other signs and symptoms. Scintillating images or flashing lights followed by headache are the classic migraine syndrome. This is untreatable except for possible pain medication.

1E Diplopia after a head blow is not uncommon and usually needs only to be monitored for improvement over the next few days and weeks.

2A Inflammation, injection can easily be treated by the optometrist with antibiotic or anti-inflammatory medications; much of this would not need to be referred if the present bill passes.

2B Corneal opacities can be old foreign body scars, long since forgotten (or never known) by the patient. We see lens opacities in developing cataract years before the cataract becomes dark enough to require removal. We usually make notes but do not always tell the patient so he will not be unduly alarmed.

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CATARACT

A cataract is an opacification of the lens or its capsule. By this definition, almost every adult has cataracts in the sense that some fine opacities are usually visible with the slit lamp in every adult lens. It is advisable, therefore, to restrict the use of the term "cataract" to opacities of the lens that materially interfere with vision. Even in the early stages of cataract, when vision is somewhat interfered with, it is probably wiser to tell the patient that he has lens opacities, rather than use the term cataract. If he asks whether this means that he is going to develop cataracts, he can be told that many times such lens opacities do not progress but remain stationary and occasionally even absorb. If they do progress and cut down his vision further, he can then be told he has a cataract. Many patients go the rest of their lives with slight impairment of vision caused by early cataracts that never increase to the point requiring an operation.

Causes of Opacification of Lens Fibers

Cataract is a loss of transparency of the lens, developing as the result of altered physical and chemical processes in its colloids. Anything which

Frances Heed Adler, Textbook of Ophthalmology, Philadelphia: W B Saunders Co., 7th edition, 1962, p. 315

2C A high cup/disc ratio is meaningless as an indicator of the need to begin glaucoma treatment unless it is corroborated by high intraocular pressure or change in the visual fields, both of which are ready optometric test procedures.

4B Tension value of 22 mm is arbitrary and, in my opinion, far too conservative, particularly when the air puff tonometer (which tends to read high) is used. Other factors, such as family history, optic cup appearance, diurnal variation and visual fields must be taken into account before deciding whether this level of tension is even marginally significant.

I hope the fallacy of requiring referral on the basis of single symptoms is readily apparent from this. To reach a diagnosis, final or even tentative, usually requires that several factors be considered in combination. One item alone is rarely meaningful. Not only would this proposal result in great numbers

of unnecessary referrals, but it would rob the highly trained professional person of his judgment. This is the real motive of ophthalmology in proposing this as a feature of a "compromise". For if they get the law to strip optometry of its professional judgment, they can begin to bring optometry under their control and eventually eliminate it as an independent profession.

Such a mandatory referral proposal has not passed in any state, though the ophthalmologists have tried. (Utah does have one that comes uncomfortably close to this). One of our ODs said in all seriousness that if this proposal should become law he would leave Alaska. If by some chance it passed, we would probably resort to the courts.

Virtually the same document was proposed by the ophthalmologists last year. They are not truly negotiating when they introduce completely new considerations that they know we cannot possibly accept, then say, "See, they aren't willing to compromise." A compromise cannot be one step forward and two steps backward.

However since I know you are all under pressure, we have developed a wording for a mandatory referral clause that we can live with, and can use as a compromise if necessary:

> All optometrists licensed under this chapter shall assist their patients in whatever manner possible in obtaining further care when in the professional judgment of the optometrist, the services of another health care practitioner are required. The practitioner to whom the patient is referred shall return the patient to the referring doctor with a detailed report of his findings and treatment.

This is not palatable, because it implies that we have done something wrong which requires such a statement. But at least it preserves the practitioner's discretion as to when and to whom he refers his patients. As a logical extension, it should be made to apply to general physicians as well, since they know far less about the eye and its diseases than optometrists do (see attached copy of Dr. Maumenee's remarks and the optometry-medical school comparisons in a booklet previously submitted).

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
Co-Chairman, Legislative Committee,
Alaska Optometric Association
Member, Board of Examiners

PWB/lr

Attachment

Chairman's Address

The Educational and Political Structure of Ophthalmology in America

A. Edward Maumenee, MD, Baltimore

THE SOCIOECONOMIC structure under which medicine is now practiced is in the process of one of its greatest changes in the history of our country. In this connection, a few items of particular interest to ophthalmologists are: the medical school curriculum and the place of ophthalmology in it; the National Eye Institute; Medicare; the Hart Bill now before the Senate; and our relationship to optometry, and its effect on Resolution 77 of the American Medical Association. It is not my intent to discuss these specific problems, but rather to outline the educational and political structure of ophthalmology in this country and to offer a few suggestions regarding the management of these conditions so that we may seek the most effective avenues to voice our opinion on these matters.

The educational aspects of this discussion are included because the faculty of our medical schools exert a major influence on the development and administration of new programs. This is particularly true today, when government agencies frequently seek the advice of academicians in establishing policies in medical aid and care.

Ophthalmology is a minor specialty in undergraduate teaching. According to Duane,[1] ophthalmology has subdepartmental (division) status in over 50% of the medical schools in the United States. The time allocated to the teaching of this specialty, even when it has departmental status, is extremely short. Thus, in most schools, only 60 to 100 hours are devoted to ophthalmology during the entire four years, as compared to 300 to 900 hours in the fields of obstetrics and gynecology, pediatrics, psychiatry, surgery, and medicine. In postgraduate education, however, ophthalmology assumes much greater importance, for the three to five years spent in residency training are comparable to those of other specialties. At present, about 10% of all outpatients and inpatients seek aid because of ocular complaints.

The role of ophthalmology in postgraduate teaching will probably increase greatly in the immediate future because of Medicare. An analysis of the patients over 65 years of age who received medical attention at The Johns Hopkins Hospital showed that 20% sought assistance because of ocular problems. A review of all discharge diagnoses at Hopkins on patients of any age revealed that cataract discharges were the

Submitted for publication June 20, 1966.

From the Wilmer Institute, Johns Hopkins Hospital, Baltimore.

Chairman's Address read before the Section on Ophthalmology at the 115th Annual Convention of the American Medical Association, Chicago, June 26-30, 1966.

Reprint requests to the Johns Hopkins Hospital, 601 N Broadway, Baltimore 21205 (Dr. Maumenee).

Compromise

FEB 23

1. Optometry would be allowed to use proparacaine 0.5% as a topical anesthetic for diagnostic purposes, 1% tropicamide or phenylephrine hydrochloride 2.5% - 5% for dilatation of the pupil for diagnostic purposes.
2. Any changes in this list of medications will be by the combined concurrence of the State Board of Optometry and the State Board of Medical Examiners.
3. A training course will be completed by each optometrist desiring to use drugs prior to any examination. The course shall consist of the following minimum subject matter:
   A. Clinical pharmacology and drug organ interactions.
   B. Cardiopulmonary resuscitation and emergency training.
   C. Techniques of clinical examination.
   D. Thorough review of clinical signs of fundus, anterior segment, and external disease as well as referral guidelines.
4. Any practitioner optometrist will take a written examination in the above by test committee comprised of two optometrists and two ophthalmologist, each chosen by their respective professional organizations to assess competency in the above.
5. When an Optometrist examines any person, he shall inform that person, parent, guardian, or other responsible party, prior to prescribing or providing eyeglasses or other services that examination by a licensed physician ~~specializing in diseases of the eye (or if no such licensed physician is available then by a duly licensed physician)~~ is indicated whenever one or more of the following conditions is present. ~~These conditions fall generally into four categories where there is.~~
   1. An abnormality of vision.
   2. An abnormality of tissue.
   3. An abnormality of motor function.
   4. Other.

[illegible] in children under 8 years of age by refractive correction by lenses, unless the cause has been medically determined by a physician and is stable or unless there is improvement within two weeks with visual therapy.

B. A complaint by the individual of a sudden appearance of spots or flashing lights, scintillating images, transient dimming or loss of vision, or distortion in the shape of objects.

C. A complaint by the individual of temporary or permanent loss of any part of the visual field.

D. A history of rainbow halos around lights in the absence of contact lens causes.

E. Diplopia (double vision) of sudden onset.

2. Tissue Abnormalities:

A. Presence of [redacted] inflammation, infection, swelling, mass or ulceration of the eye or its surrounding tissues in the absence of contact lens causes.

B. Opacities of the cornea, lens or vitreous.

C. Changes in the appearance of the optic discs.

1. Cupping greater than 0.5 cup-disc ratio (C-D).

2. Difference greater than 0.2 C-D ratio between the two eyes, that is .2 C-D one eye and .5 C-D the other eye.

3. Difference in appearance between the optic discs of each eye.

4. Change in appearance of the optic discs from a pervious exam.

5. Suspicion of elevation of the optic nerve head.

D. Observation of a deviation from the normal appearance of the retina or its vessels.

in straight ahead gaze or gaze in any direction. ~~[illegible]~~ to correct a refractive error or exercise.

~~defined [illegible] to accept.~~

B. A difference in the size of the pupils or failure to constrict with illumination or with near vision.

C. Ptosis or lag ophthalmus (drooping of the eyelids) with onset within one week of examination.

D. Nystagmus (rapidly oscillating eye movements).

4. OTHER:

A. Continuous tearing of longer than 24 hours duration or complaints of watering eyes not associated with visual tasks.

B. Intraocular tension of 22 or more on any occasion ~~or a family history of glaucoma~~

C. Any other observation or deviation from the usual appearance of the eye and related tissues or any complaint which is not attributable to the refractive state or muscle balance, or which is not amenable to lenses, prisms, or visual training.

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

Failure to comply with the provisions of the Act shall subject the offender to revocation or suspension of his licenses to practice Optometry and this Act shall take effect immediately.

It is completely understood at the outset that there is to be no Grandfather Clause attached to any of the above.

Opposition
SB 136

Dennis A. Swarner, O.D.
Robert D. O'Connell, O.D.
Doctors of Optometry
Drawer 4370
Kenai, Alaska 99611

Telephone (907) 283-7575

March 3, 1981

Mr. Charlie Parr
Pouch V
Juneau, Ak 99801

Dear Mr. Parr,

I am writing in support of Senate Bill #136. I hope you will judge this bill on it's own merits as well as the needs of the Alaskan citizens.

As a practicing Alaska Optometrist I could fill reams of paper in support of this bill but I'm sure that you are just as tired reading about the pros and cons of this bill as I am tiring of writing in it's support!!

I have a very simple solution to the problem. There are three states (Florida, North Carolina and West Virginia) that have allowed Optometrists to use the full range of Ophthalmic Drugs for several years. Look at the Optometric record relative to drug use in those states and judge accordingly.

I'm not sure how many of you folks are aware of the enormous amount of money generated by insurance companies, they usually have things pretty well figured out. Malpractice insurance for Optometrists went down nationwide last year. I'm sure not too many other professions experienced a similar reduction.

Thank you

Robert D. O'Connell, O.D.

RO/mw

members #13
SB 136

The ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PROFESSIONAL PERSPECTIVES No. 1

AETNA REDUCES ANNUAL PREMIUM FOR INSURED AOA MEMBERS

Hartford, CT--More than two years of efforts between the American Optometric Association and Aetna Life & Casulty Co. have prompted the Hartford based insurance firm to REDUCE PROFESSIONAL LIABILITY RATES FOR AOA MEMBERS BY 18 PERCENT. The high quality of professional vision care which AOA optometrists are providing has warranted this reduction. Fear expressed by ophthalmologists, in those states which allowed optometrists to use ophthalmic drugs, was unfounded. Optometry has been the ONLY major health care profession to have its liability insurance rates reduced.

Eagle River Optometric Center
Jeffrey G. Keene, O.D.
Eagle River, Alaska
Member
American Optometric Association

March 10, 1981

Charlie Parr
Chairman Senate HESS Committee
Alaska Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I had the opportunity to sit in on some of the testimony during the teleconference in regards to Senate Bill '36. There are a few points that might not have been brought forth, that I would like to address.

First, many people go to Optometrists for vision care solely because of their expertise in evaluating and solving problems of the visual system. Optometry and Ophthalmology have vastly different approaches to interpreting the visual system. This would follow in line of our educational background; Ophthalmology stresses the medical aspect of the eye (infection and disease) with much less depth in visual problems, whereas, Optometry is just the opposite. There was reference by some Ophthalmologists at the teleconference who wanted Optometrists to categorically state to their patients that they are not eye physicians. This is as absurd as mandating Ophthalmologists to state that they are not Optometrists and implying that their approach to vision care is not up to a certain standard.

The second point I wish to make is that Ophthalmology is not the only medical discipline that Optometry refers to. I have personally referred to Internists, Neurologists, Dermatologists, General Practioners and of course Ophthalmologists. This is an illustration that Optometry is a primary entry point into the health care system. Many people, especially in the 40-70 age bracket, have their eyes checked more frequently than a general medical check, therefore, it is essentiel to evaluate the eye system and the surrounding structures as thoroughly as possible not only to help detect an eye health problem but a general health problem and to refer to the proper medical discipline. This is <u>best</u> accomplished, in some instances, by the use of Opthalmic drugs.

Thirdly, it doesn't make sense that an Optometrist would not refer a patient who has need of further health care. The patients that we see are often, figuratively and literally our neighbors. Talk of mandatory referral with specialised forms and check lists is strictly a device by

Eagle River Optometric Center
Jeffrey G. Keene, O.D.
Eagle River, Alaska
member
American Optometric Association

Ophthalmology to enhance their own position at the expense of Optometry as a disciplined profession. Referral is a professional judgement based on educational and clinical experience. Nowhere in the health care system is referral mandated based on criteria set by one discipline over another. This destroys the independent professional judgement and since, referral is 'mandated' by our code of ethics and our professionalism this idea by Ophthalmology is completely unneccessary.

Finally, in regards to our educational background for the use of Ophthalmic drugs, it has to be emphasized that there are several groups of people in the state of Alaska ie., Community Health Aides, Nurse Practioners, Physicians Assistants, that use these drugs with far less training than Optometrists. Are they having a detrimental affect on the people they serve? I think not or there would be a demand for discontinuing their use. The real issue comes down not to whether Optometry or Ophthalmology will gain or lose because of this legislation but what will be the best for the people of Alaska. If this is truly kept in mind I believe this legislation will be passed. Thank you.

Sincerely,

Jeffrey G. Keene, O.D.

Jeffrey G. Keene, O.D.

JGK/amt

cc: Senate HESS Committee

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3200 GLACIER HWY.
JUNEAU, ALASKA 99801
(907) 586-3264

MARCH 9, 1981

SENATOR CHARLES PARR,
CHAIRMAN, SENATE HESS COMMITTEE
POUCH V
JUNEAU, ALASKA 99811

DEAR SENATOR PARR,

I WISH TO EXPRESS MY OPPOSITION TO SENATE BILL 136 AND HOUSE BILL 111, UNDER WHICH OPTOMETRISTS' PRACTICE PRIVELEGES WOULD BE EXTENDED TO DIAGNOSIS AND TREATMENT OF EYE DISEASE. I AM A GENERAL SURGEON PRACTICING IN JUNEAU, AND WHILE MY PRACTICE DOES NOT INVOLVE THE TREATMENT OF EYE CONDITIONS I FEEL AN OBLIGATION TO COMMENT ON BEHALF OF THE BEST MEDICAL INTERESTS OF THE PEOPLE OF ALASKA. WHILE SCHOOLS OF OPTOMETRY MAY PROVIDE SATISFACTORY TRAINING IN THEIR TRADITIONAL FIELD OF REFRACTION AND FITTING OF CORRECTIVE LENSES, THEY DO NOT PROVIDE COMPETENCE IN DIAGNOSIS AND TREATMENT OF DISEASE. THE PHARMACEUTICAL AGENTS WHICH PASSAGE OF THESE BILLS WOULD PLACE AT THE DISPOSAL OF OPTOMETRISTS CAN HAVE SYSTEMIC AS WELL AS LOCAL AFFECTS, AND THEIR USE BY ANYONE WHO IS NOT UNDER A PHYSICIAN'S SUPERVISION IS EXTREMELY QUESTIONABLE. THE PHRASE "MINOR" EYE DISEASES AS IT APPEARS IN THE BILLS TENDS TO BE MISLEADING. FIRST, NO DISEASE IS MINOR WHEN IT'S YOURS. SECOND, IT IMPLIES THE ABILITY OF THE OPTOMETRIST TO DISCRIMINATE BETWEEN A MINOR AND MAJOR EYE PROBLEM, AND TO APPROPRIATELY REFER THE MAJOR PROBLEMS. THIS PLACES THE BURDEN OF DIAGNOSIS OF MAJOR EYE PROBLEMS UPON THE OPTOMETRISTS, WHOSE COMPETENCE TO DIAGNOSE MINOR PROBLEMS IS ALREADY IN QUESTION.

THE PUBLIC AT LARGE, WHEN CONFRONTED WITH THE TERMS OPTOMETRIST AND OPHTHALMOLOGIST , HAS LITTLE APPRECIATION OF THE DIFFERENCES BETWEEN THEM IN TERMS OF TRAINING AND COMPETENCE. FOR BETTER OR WORSE, IT HAS ALWAYS BEEN A LEGISLATIVE DECISION OF WHICH ONE IS ALLOWED TO DO WHAT-THAT DETERMINES WHERE THE PATIENT GOES. I WOULD URGE YOU AND YOUR COLLEAGUES NOT TO MISLEAD THE PUBLIC BY ATTEMPTING TO LEGISLATE INTO BEING A COMPETENCE WHICH WAS NOT ATTAINED BY APPROPRIATE EDUCATION. WHILE YOU AND YOUR COLLEAGUES ARE CONSIDERING THESE BILLS PLEASE ASK YOURSELVES THE FOLLOWING QUESTION: WHAT KIND OF TRAINING AND EXPERIENCE WOULD YOU DEMAND OF ONE ENTRUSTED TO TREAT YOUR OWN EYES, OR THE EYES OF YOUR FAMILY?

SINCERELY,

W.E. ANDREWS M.D.

WEA/BJS

YUKON-KUSKOKWIM HEALTH CORPORATION

P. O. Box 528
Bethel, Alaska 99559
(907) 543-3521

March 18, 1981

The Honorable Charles H. Parr
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

This letter is to indicate Yukon-Kuskokwim Health Corporation's support of Senate Bill No. 136, "an act relating to the practice of optometry and authorizing the use of ophthalmic drugs by optometrists." The reasons for supporting the bill are as follows:

For more than two years YKHC's optometrist has been using diagnostic and therapeutic drugs under standing orders from the Indian Health Service physicians. There have been no negative reactions to this.

The fact is that the use of ophthalmic drugs has enabled the optometrist to do a more thorough examination and to detect certain eye pathologies, such as narrow angle glaucoma and retinal detachments, then make referrals to the ophthalmologist for appropriate therapy. If the optometrist had not used ophthalmic drugs, certain pathologies probably would have gone undetected.

We believe that all optometrists, those in private practice and those not in private practice, should be able to use certain diagnostic and therapeutic drugs. In our opinion, this would redound to the benefit of the patient and, also, would allow optometrists to maximize the use of their training and skills.

We urge your support of Senate Bill No. 136.

Sincerely,

Mary Pavil
Executive Director

Sue Martin
Assistant Health Director

MP/SM/to

cc: Senator George Hohman
Representative Tony Vaska
Jim Martin
Sue Martin
John Demaske, O.D.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1977

S 2

SENATE BILL 424*
Second Edition Engrossed 5/24/77

Short Title: Redefine Optometry. (Public)

Sponsors: Senators Hardison; Kincaid, Combs, Mathis, Raynor, Popkin, Lawing, Webster, Scott, Alexander.

Referred to: Judiciary II.

April 6, 1977

A BILL TO BE ENTITLED

AN ACT TO REDEFINE THE PRACTICE OF OPTOMETRY CONSISTENT WITH MODERN ADVANCES IN SCIENCE AND OPTOMETRY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-114 as the same appears in the 1975 Replacement Volume 2C of the General Statutes is hereby amended and rewritten to read as follows:

"§ 90-114. Optometry defined.--Any one or any combination of the following practices shall constitute the practice of optometry:

(1) the examination of the human eye by any method, other than surgery, to diagnose, to treat, or to refer for consultation or treatment any abnormal condition of the human eye and its adnexa; or

(2) the employment of instruments, devices, pharmaceutical agents and procedures, other than surgery, intended for the purposes of investigating, examining, treating, diagnosing or correcting visual defects or abnormal conditions of the human eye or its adnexa; or

(3) the prescribing and application of lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision training, pharmaceutical agents, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

Provided, however, in using or prescribing pharmaceutical agents, other than topical pharmaceutical agents within the definition hereinabove set out which are used for the purpose of examining the eye, the optometrist so using or prescribing shall communicate and collaborate with a physician duly licensed to practice medicine in North Carolina designated or agreed to by the patient. "

Sec. 2. G.S. 90-118 as the same appears in the 1975 Replacement Volume 2C of the General Statutes and in the 1975 Cumulative Supplement thereto is hereby amended by adding at the end thereof a new subsection (e) to read as follows:

"(e) The board shall not license any person to practice optometry in the State of North Carolina beyond the scope of the person's educational training as determined by the board. No optometrist presently licensed in this State shall prescribe and use pharmaceutical agents in the practice of optometry unless and until he (i) has submitted to the board evidence of satisfactory completion of all educational requirements established by the board to prescribe and use pharmaceutical agents in the practice of optometry and (ii) has been certified by the board as educationally qualified to prescribe and use pharmaceutical agents.

Provided, however, that no course or courses in pharmacology

shall be approved by the board unless (i) taught by an institution having facilities for both the didactic and clinical instruction in pharmacology and which is accredited by a regional or professional accrediting organization that is recognized and approved by the Council on Postsecondary Accreditation or the United States Office of Education and (ii) transcript credit for the course or courses is certified to the board by the institution as being equivalent in both hours and content to those courses in pharmacology required by the other licensing boards in this Chapter whose licensees or registrants are permitted the use of pharmaceutical agents in the course of their professional practice."

Sec. 3. G.S. 90-118.10 as the same appears in the 1975 Replacement Volume 2C of the General Statutes is hereby amended by adding at the end thereof a new paragraph to read as follows:

"In issuing a certificate of renewal, the board shall expressly state whether such person, otherwise licensed in the practice of optometry, has been certified to prescribe and use pharmaceutical agents."

Sec. 4. G.S. 90-118.11 as the same appears in the 1975 Replacement Volume 2C of the General Statutes is hereby amended by inserting in line 8 thereof immediately following the word "refused" and before the semicolon the words:

"; or shall practice or attempt to practice optometry by means or methods that the board has determined is beyond the scope of the person's educational training".

Sec. 5. Article 6 of Chapter 90 of the General Statutes is hereby amended by inserting therein a new section G.S. 90-

|25.| to read as follows:

"§ 90-|25.|. Filling prescriptions.--Legally licensed druggists of this State may fill prescriptions of optometrists duly licensed by the North Carolina State Board of Examiners in Optometry to prescribe, apply or use pharmaceutical agents."

Sec. 6. G.S. 90-87(22)(a) as the same appears in the |975 Replacement Volume 2C of the General Statutes is hereby amended by inserting in line | thereof immediately following the word "dentist," and preceding the word "veterinarian" the word "optometrist,".

Sec. 7. The provisions of this act are applicable only to those individuals licensed pursuant thereto and

shall not] restrict, expand, or otherwise alter those other practices or acts governed by Chapter 90 of the General Statutes.

Sec. 8. This act shall become effective on and after July |, |977.

AMERICAN OPTOMETRIC ASSOCIATION

BULLETIN
from
OFFICE OF COUNSEL

VOLUME XXXV, BULLETIN NO. 84 June 6, 1977

TO: O, T, DEC-C, EMS, E, NE, GC, State Association Presidents, Executives, Legal-Legislative Chairmen, Attorneys, Legislative Counsel, Optometric Legislators, IAB-EC, State Board Presidents, Secretaries, Attorneys, Administrative Heads of Schools and Colleges, COE-ES, CCOC-ES, Drs. Rhodes, Rush

FROM: Thomas E. Eichhorst, Counsel

SUBJECT: North Carolina Legislation

The General Assembly of North Carolina has enacted into law Senate Bill 424, as amended. This law permits optometrists to utilize pharmaceutical agents "to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa. Provided, however, in using or prescribing pharmaceutical agents, other than topical pharmaceutical agents within the definition hereinabove set out which are used for the purpose of examining the eye, the optometrist so using or prescribing shall communicate and collaborate with a physician duly licensed to practice medicine in North Carolina designated or agreed to by the patient."

A copy of this bill, as enacted, is enclosed. The bill in its final form passed the Senate on May 24, 1977 by a vote of 46 to 4, and the House of Representatives on June 3, 1977 by a vote of 93 to 4. In North Carolina, the Governor has no veto power, so enactment by both houses of the legislature is final.

North Carolina is the fourteenth state to enact legislation authorizing optometrists to utilize pharmaceutical agents. Twelve other states authorize optometrists to utilize diagnostic pharmaceutical agents; the dates of the enactment of these laws are Rhode Island (July 16, 1971), Pennsylvania (March 1, 1974), Tennessee (May 8, 1975), Oregon (May 20, 1975), Maine (June 24, 1975), Louisiana (July 6, 1975), Delaware (July 10, 1975), California (July 9, 1976), Wyoming (February 17, 1977), New Mexico (March 4, 1977), Montana (April 12, 1977 at 10:10 a.m.), and Kansas (April 12, 1977 at 2:00 p.m.). On March 4, 1976, the West Virginia Legislature authorized the use of drugs for diagnostic or therapeutic purposes by optometrists who meet educational requirements set by the optometry board.

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

SB 136 file (my file)

Alaska State Legislature

Senate

Committee on State Affairs

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

M E M O R A N D U M

TO: SENATOR CHARLIE PARR

FROM: SENATOR VIC FISCHER VF

DATE: FEB. 19, 1981

RE: SB 136 Relating to the practice of optometry

Charlie---I've had quite a few people talk to me about this legislation, both optometrists and opthalmologists. For whatever it's worth, here are my current thoughts.

Some legislation appears justified. At the same time, vague language and inadequate distinctions between what optometrists and opthalmologists do should be avoided. Aside from making sure that language is specific and clear, we might well consider bringing in some clear definition of opthalmology, o the turf upon which optometrists do not transcend.

Thanks for your attention.

Penn

§ 225. Suspensions and revocations, how made; notice, hearing, adjudication and appeal; reissuance of license

1. Construction and application

State board of nurse examiners committed prejudicial error in disciplinary hearing by sustaining objections of board counsel to cross-examination of complaining witness concerning pending civil suits she had instituted against registered nurse and hospital based on incident which was subject of disciplinary hearing. Leukhardt v. Com., State Bd. of Nurse Examiners, Bureau of Professional & Occupational Affairs, 403 A.2d 645, Cmwlth.1979.

Phrase "after a full and fair hearing before the Board," within provision of this section that all suspensions and revocations shall be made only in accordance with regulations of Board and only by majority vote of members of the Board after a full and fair hearing before the Board, does not require all members of the Board to be present at hearings in order to constitute a "body" of the Board, but merely dictates that the decisions and actions of the Board be adopted by the full Board. Ulio v. Com., State Bd. of Nurse Examiners, 398 A.2d 764, 41 Pa.Cmwlth. 204, 1979.

Absence of certain members of the State Board of Nurse Examiners during taking of certain testimony in respect to suspension of petitioner's license as a registered nurse did not serve to invalidate subsequent suspension order where a quorum was present at time Board convened and determined to suspend petitioner. Id.

CHAPTER 8.—OPTOMETRISTS

Rules and Regulations

State board of optometrical examiners, see 49 Pa.Code § 23.1 et seq.

§ 231. "Optometry" defined

That the practice of optometry is hereby defined to be the employment of any means or methods, other than the use of surgery, or drugs, except diagnostic pharmaceutical agents known generically as cycloplegics, mydriatics, topical anesthetics and miotics which are administered topically for the examination of the human eye and the analysis of ocular functions, or the prescribing, providing, furnishing, adapting or employing any or all kinds and types of lenses and prisms, visual training orthoptics, ocular exercises, and any and all preventive and corrective methods for the aid, correction or relief of the human eye, its associated structures, appendages and functions, other than the use of drugs or surgery. The Secretary of Health shall designate the specific agents to be used under the above generic classification: Provided, however, That with respect to optometrists licensed at the time of the effective date of this amendatory act, only such licensed optometrists who (i) have satisfactorily completed a course in pharmacology, as it applies to optometry, by an institution accredited by a regional or professional accreditation organization which is recognised or approved by the National Commission on Accrediting or the United States Commissioner of Education, with particular emphasis on the topical application of diagnostic pharmaceutical agents to the eye for the purpose of examination of the human eye and the analysis of ocular functions, approved by the State Board of Optometrical Examiners, and (ii) who upon successful completion of such course shall be permitted by the State Board of Optometrical Examiners in Optometry to use diagnostic pharmaceutical agents topically in the practice of optometry. Whenever an optometrist during the course of his examination of a person shall determine the possibility of the existence of a pathological condition he shall advise the person of such opinion and refer such person to a physician for further evaluation.

The term "optometrist" means a person who practices optometry in accordance with the provisions of this act.

As amended 1974, March 1, P.L. 120, No. 39, § 1.

1974 Amendment. Rewrote the section.

Cross References

Child protective services, see 11 P.S. § 2201 et seq.

Medical Practice Act, applicability, see section 421.17 of this title.

Osteopathic Medical Practice Act, application to optometry, see § 271.17 of this title.

Peer review protection, health care professionals, see sections 425.1 to 425.4 of this title.

Supplementary Index to Notes

Acupuncture 2.5

2. Construction and application

The Optometry Law of 1917 (this section et seq.) only authorizes the State Board of Optometrical Examiners to regulate the registration of optometrists and the conduct of examinations and not the practice of optometry. State Bd. of Op-

tometrical Examiners v. Campbell, 90 Dauph. 92, 1968.

The regulation of optometry is within the police power of the state but the manner of regulation must be reasonable and must have a substantial relation to the end to be attained. The true exercise of the police power can and must concern itself with the safety and well being of the public in general and the patients of optometrists in particular. Id.

2.5 Acupuncture

Optometrists may not engage in practice of acupuncture. 1974 Op.Atty.Gen. No. 39.

§ 232. Practice without license unlawful; penalties

Supplementary Index to Notes

Injunctive 3

1. Validity

Provision of this section forbidding the practice of optometry by unlicensed persons, constitutes a reasonable and lawful exercise of the state's powers to protect the health, safety and welfare of the people, and is therefore not violative either of the Fourteenth Amendment of the United States Constitution (U.S.C.A.Const. Amend. 14) or Const. Art. 1, § 9. Neill v. Wall and Ochs, Inc., 68 D. & C.2d 429, 1973.

2. Construction and application

Although defendant sometimes works in a capacity ancillary to an opthalmologist, he is not entitled to the protection of the exemption granted by the act to physicians and surgeons. Pennsylvania Optometric Ass'n, Inc. v. DiGiovanni, 45 D. & C.2d 247, 1968.

3. Injunction

In an action by licensed optometrists in their own behalf and as members of an optometric association to enjoin defendant, an optician, from practicing optometry where it appears defendant examined the human eye, analyzed its functions, prescribed contact lenses for his customers and provided and adapted the lenses to aid and correct their vision, such acts constituted the unlicensed practice of optometry in violation of section 231 of this title and defendant would be enjoined from continuing the practice. Pennsylvania Optometric Ass'n, Inc. v. DiGiovanni, 45 D. & C.2d 245, 1968.

§ 233. Examinations, eligibility of applicants

Every person desiring to commence the practice of optometry, or, if now in practice, to continue the practice thereof after January first, one thousand nine hundred and eighteen, except as herein otherwise provided, shall take the examination provided in this act, and satisfy the other requirements hereof as here provided. Any person who has been engaged in the practice of optometry in this Commonwealth for two full years prior to the passage of this act, or for one year in this and for the year preceding it in another State, and is of good character, shall be entitled to take a limited examination covering the following only:

(a) The limitation of the sphere of optometry.

(b) The necessary scientific instruments used.

(c) The form and power of lenses used.

(d) A correct method of measuring presbyopia, hypermetropia, myopia, and astigmatism.

(e) The writing of formulae or prescriptions for the adaptation of lenses in aid of vision.

The board shall also permit the taking of limited examinations by, and the license, of any person who shall apply therefor before the first day of January, one thousand nine hundred and twenty-two, who, at the time of the passage of the act to which this is an amendment or the time when the limited examinations under said act were held, was unavoidably absent from this State on account of service in the army or navy of the United States, or who was at such time or times otherwise unavoidably absent from this State, or was physically handicapped and unable to take such examination: Provided, however, That any such person shall have engaged in the practice of optometry in this Commonwealth for two full years prior to the passage of the act to which this is an amendment, or for one year in this Commonwealth and one year in another State, and shall be of good character.

Any person who, at the time of the passage of the act to which this is an amendment, was unavoidably absent from this State on account of service in the army or navy of the United States, or who was otherwise unavoidably absent from this State, or was physically handicapped and unable to take the examination, and who was actually engaged in the practice of optometry, but who had engaged in such practice less than two years; and any person over the age of twenty-one years, of good

West Virginia

ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 1005

(By Mr. Sommerville,)

(Originating in the House Committee on the Judiciary.)

[Passed February 20, 1976; in effect ninety days from passage.]

AN ACT to amend and reenact section one, article five, and sections two, four and five, article eight, all of chapter thirty of the code of West Virginia, one thousand nine hundred thirty-one, as amended, relating to the profession of optometry; adding, within the definition of "prescription," optometrist to the licensed professionals who order drugs or medicines or combinations or mixtures thereof in certain cases; providing for the redefinition of the practice of optometry; exempting the practice of osteopathy from the provisions of law regulating the practice of optometry; accreditation of schools and colleges of optemetry and the qualifications, education, examination and certification of applicants to practice optometry.

Be it enacted by the Legislature of West Virginia:

That section one, article five, and sections two, four and five, article eight, all of chapter thirty of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted to read as follows:

ARTICLE 5. PHARMACISTS, ASSISTANT PHARMACISTS AND DRUGSTORES.

§30-5-1. Definitions.

The following words and phrases as used in this article, shall have the following meanings, unless the context otherwise requires

(1) The term "drug" means (a) articles in the official United States Pharmacopoeia, or official National Formulary, or any other supplement to either of them, which are intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals, and (b) all other articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals, and (c) articles, other than food, intended to affect the structure or any function of the body of man or other animals and (d) articles intended for use as a component of any articles specified in clause (a), (b), or (c).

(2) The term "poisonous drug" means any drug likely to be destructive to adult human life in quantities of five grains or less.

(3) The term "deleterious drug" means any drug likely to be destructive to adult human life in quantites of sixty grains or less.

(4) The term "habit-forming drug" means any drug which has been or may be designated as habit forming under the regulations promulgated in accordance with Section 502 (d) of the Federal Food, Drug and Cosmetic Act of June twenty-fifth, nineteen hundred and thirty-eight.

(5) The term "pharmacy" or "drugstore" or "apothecary" shall be held to mean and include every store or shop or other place (a) where drugs are dispensed, or sold at retail, or displayed for sale at retail, or (b) where physicians' prescriptions are compounded, or (c) which has upon it or displayed within it, or affixed to or used in connection with it, a sign bearing the word or words "pharmacy," "pharmacists," "apothecary," "drugstore," "drugs," "druggists," "medicine," "medicine store," "drug sundries," "remedies," or any

word or words of similar or like import; or (d) any store or shop or other place, with respect to which any of the above words are used in any advertisement.

(6) The term "prescription" shall be held to mean an order for drugs or medicines or combinations or mixtures thereof, written or signed by a duly licensed physician, dentist, optometrist, as authorized by section two, article eight of this chapter, veterinarian or other medical practitioner licensed to write prescriptions intended for the treatment or prevention of disease of man or animals. The term "prescription" shall also include orders for drugs or medicines or combinations or mixtures thereof transmitted to the pharmacist by word of mouth, telephone or other means of communication by a duly licensed physician, dentist, optometrist, veterinarian or other medical practitioner licensed to write prescriptions intended for treatment or prevention of disease of man or animals, and such prescriptions received by word of mouth, telephone or other means of communication shall be recorded in writing by the pharmacist and the record so made by the pharmacist shall constitute the original prescription to be filed by the pharmacist. All such prescriptions shall be preserved on file for a period of five years, subject to inspection by the proper officer of the law. The above shall apply except for narcotic prescriptions, when all narcotic laws and regulations must be complied with.

(7) The term "cosmetic," which shall be held to include "dentifrice" and "toilet article," means (a) articles intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body, or any part thereof for cleansing, beautifying, promoting attractiveness, or altering the appearance, and (b) articles intended for use as a component of any such articles, except that such term shall not include soap.

ARTICLE 8. OPTOMETRISTS.

§30-8-2. Practice of optometry defined.

Any one or any combination of the following practices shall constitute the practice of optometry:

(a) The examination of the human eye, with or without

the use of drugs prescribable for the human eye, which drugs may be used for diagnostic or therapeutic purposes for topical application to the anterior segment of the human eye only, and, by any method other than surgery, to diagnose, to treat or to refer for consultation or treatment any abnormal condition of the human eye or its appendages;

(b) The employment without the use of surgery of any instrument, device, method or diagnostic or therapeutic drug for topical application to the anterior segment of the human eye intended for the purpose of investigating, examining, treating, diagnosing, improving or correcting any visual defect or abnormal condition of the human eye or its appendages;

(c) The prescribing and application or the replacement or duplication of lenses, prisms, contact lenses, orthoptics, vision training, vision rehabilitation, diagnostic or therapeutic drugs for topical application to the anterior segment of the human eye, or the furnishing or providing of any prosthetic device, or any other method other than surgery necessary to correct or relieve any defects or abnormal conditions of the human eye or its appendages.

Nothing in this section shall be construed to permit an optometrist to perform surgery, use drugs by injection or to use or prescribe any drug for other than the specific purposes authorized by this section.

§30-8-4. Registration prerequisite to practice of optometry; exceptions.

No person shall practice or offer to practice optometry in this state without first applying for and obtaining a certificate of registration for such purpose from the West Virginia board of optometry, but the following persons, firms and corporations are exempt from the operation of this article, except as hereinafter provided:

(a) Persons who have heretofore been registered as optometrists in this state, or who were engaged in the practice of optometry in this state before the passage of any law by this state regulating such practice, and who have heretofore received from the board of examiners certificates of exemption from examination;

(b) Persons authorized under the laws of this state to practice medicine and surgery or osteopathy;

(c) Persons, firms and corporations who sell eyeglasses or spectacles in a store, shop or other permanently established place of business on prescriptions from persons authorized under the laws of this state to practice either optometry or medicine and surgery;

(d) Persons, firms and corporations who manufacture or deal in eyeglasses or spectacles in a store, shop or other permanently established place of business, and who neither practice nor attempt to practice optometry.

§30-8-5. Qualifications of applicant for registration; examination.

An applicant for registration shall present satisfactory evidence that he is at least eighteen years of age, of good moral character and temperate habits, and has graduated from a high school or secondary school, or has completed an equivalent course of study approved by the West Virginia board of optometry, has satisfactorily completed all preoptometry or premedical college requirements and has graduated from a school or college of optometry approved by said board. No school or college of optometry shall be approved by the West Virginia board of optometry unless at first it has been accredited by a regional or professional accreditation organization which is recognized by the national commission on accreditation or the United States commission of education. Each applicant shall submit to and be examined in all phases of optometry as is provided by the school or college of optometry and shall include, but not be limited to, anatomy and physiology of the human eye, the use of instruments such as the ophthalmoscope, retinoscope, tonometer, slit lamp biomicroscope, the general laws of optics and refraction, general and ocular pharmacology, general and ocular pathology and other such subjects or instrumentation as the board of optometry may deem necessary.

The West Virginia board of optometry shall be responsible to determine the educational training received by the applicant from the schools and colleges of optometry, the educational qualifications of each applicant and the administering of the

examination and certifications of each applicant commensurate with his education. No optometrist shall be registered or certified to practice optometry in the state of West Virginia in any area that is beyond the scope of his educational training as determined by the West Virginia board of optometry; *Provided*, That any optometrist presently registered in the state of West Virginia and who desires to employ the use of pharmaceutical agents must submit to the West Virginia board of optometry evidence of satisfactory completion of all necessary educational requirements as made mandatory by the West Virginia board of optometry; *Provided further*, That the West Virginia board of optometry shall provide for continuing educational requirements to be completed from time to time by all optometrists desiring to employ the use of pharmaceutical agents.

AMERICAN OPTOMETRIC ASSOCIATION

BULLETIN

from

COUNSEL

VOLUME XXXIV, BULLETIN NO. 62 March 8, 1976

TO: State Association Presidents, Legal-Legislative Chairmen, Attorneys, Executives

FROM: Thomas E. Eichhorst, J.D., Counsel; AOA, St. Louis

SUBJECT: West Virginia Legislation

DIST: O, T, Drs. Rhodes, Rush, Division Executive Committee Chairmen, ED, WOD, GC, C, AA, Division Directors, E, NE, Administrative Heads of Schools and Colleges

The West Virginia Legislature has enacted Committee Substitute for H.B. 1005 (as amended). The West Virginia House of Delegates (the lower house) on Monday, February 16, 1976 passed the bill by a vote of 58 to 39. On Friday, February 20, 1976 the state Senate passed the bill by a vote of 27 to 4. Governor Arch A. Moore, Jr., vetoed the bill on Saturday, February 28, 1976.

On Tuesday, March 2, 1976 the House considered the measure again. An amendment was proposed to strike therapeutics and treatment from the bill. This amendment was defeated 53 to 44. Then the House voted to override the Governor's veto by a vote of 59 to 39. (In West Virginia, unlike most states, there is no 2/3 vote requirement to override; only a 51% of the elected membership is needed.) On Thursday, March 4, 1976 the Senate defeated by a voice and standing vote the amendment to strike therapeutics and treatment. Then the Senate voted to override the veto by a vote of 27 to 6.

A copy of this new law is attached. The notations (on pages 6 and 10) indicate amendments made by the House of Delegates before the initial passage of the bill.

(provided by the Alaska
(Optometric Assoc. 2-27-81

DEFINITIONS

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

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

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

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

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

March 13, 1981

The Honorable Charles H. Parr
Chairman, Senate Health, Education
and Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I am concerned that if the legislation embodied in SB 136 is not to be obsolete the moment it is written, it should recognize the full scope of present education in optometry. This includes the use of chemotherapeutic agents like antibiotics.

At present, two optometry schools serving the "therapeutic" states have well established clinical programs in ocular therapeutics. By this I mean students clinicians are actually using drugs therapeutically in the clinic. These schools are the Pennsylvania College of Optometry in Philadelphia and the Southern College of Optometry in Memphis. Other therapeutic programs are in various stages of development in the other optometry schools. Pennsylvania and Southern both offer this training in postgraduate form to existing practitioners, so Alaskan optometrists can avail themselves of it. I would envision the Board of Examiners endorsing ODs' certificates for diagnostic and therapeutic or diagnostic only, depending on the training they have completed.

This training is far superior to that given the undergraduate medical student. The postgraduate course offered by Pennsylvania in drugs alone comprises 105 curriculum (clock) hours of instruction and application. By contrast, a recently published survey of medical schools (attached) indicates that total required instruction in ophthalmology averages 22 hours, and many of those are taken up with learning basic anatomy, physiology and pathology of the eye, areas occupying multiple courses in optometry school. Yet medical school graduates can and do use the drugs we are seeking to use.

At the same time, I am aware that compromises in our bill may have to be achieved. I have suggested to Senator Colletta at his request, a possible constraint upon the Board of Examiners as to whom it consults in the process of implementing the legislation. A copy of that letter is attached.

There are additional limitations on statutory authority that could be imposed upon the board without significantly impairing the primary care services that will be of most benefit to the people of Alaska. In regard to therapeutics, the categories of drugs allowed are not as important as the three principal routes of administration, for the latter correspond to three levels of sophistication in the treatment of eye diseases. Those, in turn, relate to the location and severity of infections or inflammations of the eye. The routes, with commentary, are:

1. Topical application (eye drops and ointments)

Useful for "pink eye" (conjunctivitis), superficial infections of the cornea, irritation due to allergy, lid inflammations, prevention of infection in scratched eye. Most cases of simple glaucoma also respond well to drops. Topical treatment is well within the capability of optometrists trained in therapeutics.

2. Oral (tablets, capsules)

Primarily antibiotics. Often necessary as an adjunct to topical in deep or severe corneal infections. Usually necessary in infections deeper in the eye. While dentists use systemic antibiotics routinely and safely to clear up abscesses, I believe that optometrists are best advised at the present time to refer such cases to the specialist. While the board would probably exclude orals by regulation, they could also be excluded by statute without impairing the viability of the primary care concept.

3. Injection (intramuscular, intravenous, retrobulbar, subconjunctival, rarely intraocular)

These are also used for deep infections where topical application cannot deliver a sufficient quantity of antibiotic to the site of infection to be effective or where the effective oral dose would create undesirable side effects. This is definitely beyond the scope of present training in optometry and should be excluded.

Of the three therapeutic states, Florida and North Carolina do not restrict the route of administration by statute; discretion in this area is exercized by the boards. West Virginia specifies topical application.

While we would like to see the board free to run its own show, a statute adequate for some time to come would limit drug utilization to corneal anesthetics, mydriatics (pupil dilators), miotics (pupil constrictors), cycloplegics (ocular focus held constant) and topical therapeutic agents. A possible wording is circled in the enclosed West Virginia law (p. 4).

Another restriction might be the specification in statute that anyone who has graduated or last used drugs more than three years before applying for endorsement under this act must re-take the required pharmacology training. This would be slightly unfair to a number of the younger graduates who have had the training, but it could be argued that their skills have gotten rusty in the interim. It would also get the board off the hook as to where to draw the line.

Other possible amendments include:

1. Directing the board to specify continuing education requirements, as in the West Virginia law (p. 6, line 37).

2. Specifying the Pharmacology section of the National Board Examination in Optometry as the board's examination.

3. Requiring the board to report to the legislature in 3 to 5 years, detailing drug usage, side effects reported, etc.

4. Requiring training in cardiopulmonary resuscitation (CPR).

5. Mandatory referral statement from my letter of March 6.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
Member, Board of Examiners
in Optometry
Co-Chairman, Legislative Committee,
Alaska Optometric Association

PWB/lr

3 enclosures

notion and has emphasized to trainees that the hospital does not endorse them as being competent to engage in family practice. However, since state laws permit an M.D. licensee to do any type of practice he wishes, it is the feeling of the director that the public would be better served by potential family practitioners having some rather than no additional training. Since there are a number of physicians seeking some training to change their specialty, consideration should be given to longer hospital training periods or a return to specially designed preceptorships to accommodate them.

With respect to those family doctors in retraining, the program would be improved by a more specific set of goals and more careful monitoring of achievements than has as yet been accomplished. The author is aware of two other programs offering similar training. At Creighton University School of Medicine rural family doctors are trained in a specific area, for example, cardiology techniques such as Swan-Ganz catheter insertion. At the Medical College of Pennsylvania inactive physicians or physicians in administrative positions are being trained in primary care.

Conclusions

A pilot minifesidency in family practice has been in operation at Santa Monica Hospital Medical Center since 1979. Many of the applicants were practicing in other specialties and seeking to make a change to family practice. It is unrealistic to expect that the available two- to six-week period can accomplish this objective, and there is a need for a different kind of program to accommodate such circumstances. Training goals for family doctor residency refresher training must be more specific and evaluations more formal than is now the case in the Santa Monica experience.

Ophthalmology Teaching in Medical Schools

Robert E. Kalina, M.D., Henry J. L. Van Dyk, M.D., and George W. Weinstein, M.D.

The Association of University Professors of Ophthalmology (AUPO) was founded in 1965 and is made up of the chairmen of all departments or divisions of ophthalmology in U.S. medical schools (1). A major interest of the body, individually and collectively, is medical student education.

Some members of the AUPO believe that recent medical school graduates are less well prepared in ophthalmology than those of the more distant past. Also reduced familiarity with ophthalmology by physicians in future generations has been cited as a potential problem in the legislative and legal arena (2).

The results of two AUPO surveys of ophthalmology teaching are reported here.

Survey Techniques

Questionnaires were mailed in 1974 and again in 1979 to the members of the AUPO. Each member was asked to complete the form or to forward it to the individual in his unit most responsible for medical student education. Confidentiality was optional and was elected by some.

The survey document used in 1979 duplicated the questions of 1974 and in addition

This survey was supported in part by a grant to the University of Washington from Research to Prevent Blindness, Inc.

Dr. Kalina is professor and chairman, Department of Ophthalmology, University of Washington School of Medicine, Seattle. Dr. Van Dyk is professor, Department of Ophthalmology, Louisiana State University School of Medicine, New Orleans. Dr. Weinstein is professor and chairman, Department of Ophthalmology, West Virginia University School of Medicine, Morgantown.

JOURNAL OF MEDICAL EDUCATION
Vol. 56 No. 2 FEB. 1981

inquired about the usage and usefulness of the *Ophthalmology Study Guide for Students and Practitioners of Medicine*, a joint publication of the AUPO and the American Academy of Ophthalmology and Otolaryngology (AAOO) which first appeared in 1976 and now is in its third edition (3). This guide is based upon seven objective areas thought to represent essential knowledge requirements for all physicians. These objectives were developed as a result of a survey of 1,600 respondents representing medicine at undergraduate and graduate levels of general and specialty orientation (4, 5).

Results

Responses were received from 74 of 102 member schools in 1974 (73 percent) and from 81 of 110 schools in 1979 (74 percent) (Figure 1). There was a decline in mean required curriculum hours from 25 in 1974 to 22 in 1979, while the median declined from 18 to 15. Hours actually assigned to the department or division of ophthalmology decreased proportionately from a mean of 22 in 1974 to 20 in 1979. Assigned hours were used most frequently for lectures or demonstrations.

All responding institutions offered medical student electives in ophthalmology in 1979, but only a minority of students chose them (mean 25 percent, median 15 percent). Use of audiovisual self-instruction units rose from 66 percent in 1974 to 82 percent in 1979.

The study guide, not available in 1974, had been adopted as a syllabus by 58 percent of institutions in 1979, while 28 percent used another syllabus, usually prepared locally. In most cases the study guide was purchased by the student and used for self-instruction as a supplement to lectures. The microillustrations, newly added in the [illegible]tion (1978), had been found useful by [illegible]s in 67 percent of schools using the study guide.

Discussion

The surveys reported here were prompted in part by suspicion among the AUPO members that curriculum time devoted to ophthalmology had suffered during the widespread curriculum revisions which have taken place in U.S. medical schools during recent years.

Although data are not available from the preceding era, the results of the study reported here indicate that currently assigned time for

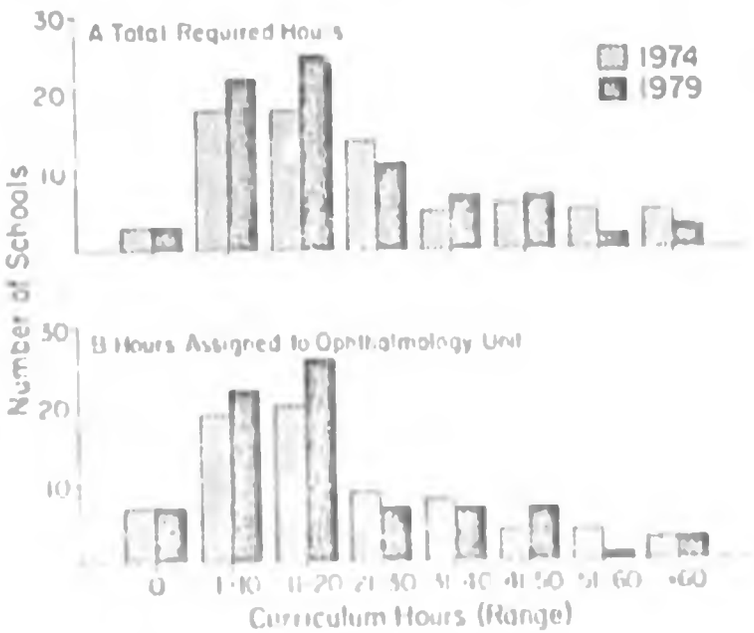

FIGURE 1

Minimum requirements for ophthalmology in U.S. medical schools

teaching ophthalmology is limited and gradually declining. One logical extension might be a declining ability for appropriate diagnosis, management, or referral of patients with eye disorders, who form a significant segment of those seeking primary care.

The results of these surveys may not include ophthalmology teaching done in the primary care clinical setting. It seems likely that such on-site instruction would be effective and appear relevant to students in that the patient-problem-teacher loop is shortest there; but the authors believe that such teaching events are rare, often unscheduled, and likely to be the first to suffer from time constraints.

Knowledge that curriculum time was limited and that competition for it was keen was one of the prime motivating factors for the development of the AAOO/AUPO study guide. Standardization of objectives to be achieved was presumed then as now to be a laudatory goal. However, the availability of clearly defined objectives has coincided with apparent reduced national curricular emphasis upon ophthalmology.

Not only is the curricular time available to ophthalmology small, but also surprisingly few students (25 percent) choose ophthalmology electives. The reasons for limited elective participation may range from the influence of counselors to lack of available electives. Whatever the cause, the effect must be negative upon student appreciation for what the specialty offers. In view of the excess of candidates for the limited number of ophthalmology residency positions, a main concern is that students who will practice other specialties, especially primary care, learn proper diagnosis and treatment of some ophthalmic disorders so that they may avoid inappropriate referral to medical or nonmedical practitioners.

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5. Spivey, B. E. Ophthalmology for Medical Students: Content and Comment. *Arch. Ophthalmol.*, 84:368–375, 1970

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

January 22, 1980

Dear Legislator:

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

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

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

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

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

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

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

treatment.

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

Respectfully yours,

Freda J. Staymaker

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

FJS/scp

WEST VIRGINIA BOARD OF OPTOMETRY

J. GORDON BUTTERFIELD, O.D.
SECRETARY TREASURER
WEST VIRGINIA BOARD OF OPTOMETRY
111 BROOKS STREET
CHARLESTON, WEST VIRGINIA 25301

January 22, 1980

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

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

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

Dear President Brotherton and Speaker See:

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

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

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

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

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

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

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

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

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

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

Sincerely yours,

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

JGB/scp

COMPARATIVE PHARMACOLOGICAL INSTRUCTION FOR

HEALTH CARE PROFESSIONS

PROFESSION	SCHOOL	PHARMACOLOGY HOURS OF INSTRUCTION	REFERENCE	RESTRICTION ON DRUG USE IN WEST VIRGINIA
Optometry	Southern College of Optometry	Total = 204 Lecture = 156 hours (Ocular & Systemic) Lab = 48 hours Plus 696 hours Clinical use of FDA Classified Drugs. Plus 180 hours of Elective Seminars attended by 80% of students.	Catalog of Southern College of Optometry 1979-80	Topically applied Ophthalmic Drugs as permitted in Enrolled H.B. 1005 March 1976
Dentistry	University of Tennessee Center for Health Sciences/ Memphis	Total = 70 hours Lecture = 40 hours Lab = 30 hours Plus Clinical use of drugs	General Catalog The University of Tennessee Center for Health Sciences/ Memphis 1978-79	NONE
Medicine	University of Tennessee Medical Units/ Memphis	Total = 187 hours Lecture = 88 hours Lab = 99 hours Plus Clinical use of drugs for 17 months *Clinical use of ocular drugs probably less than 2% of other drugs since Ophthalmology represents only 1.1% of total curriculum	General Catalog The University of Tennessee Medical Units/ Memphis 1973-74	NONE
Podiatry	Pennsylvania College of Podiatric Medicine	Total = 176 hours	Pennsylvania College of Podiatric Medicine 1977-79	NONE
Osteopathy	Philadelphia College of Osteopathic Medicine	Total = 156	Bulletin of Philadelphia College of Osteopathic Medicine 1978-79	NONE

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

March 13, 1981

The Honorable Mike Colletta
Health, Education and Social
Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Colletta:

In response to your request that I develop items of possible compromise regarding SB 136, the following provision is suggested as an addition to the bill. It relates to the power of the board to adopt regulations, which subject was the main topic of our discussion on March 11.

* Sec. 4. AS 08.72.050(4) is amended to read:

(4) necessary to govern the practice of optometry[;]. subject to the following provision: regulations defining and specifying ophthalmic drugs which may be used by optometrists shall be adopted in consultation with the Director of Public Health of the Alaska Department of Health and Social Services;

This would insure continuing input and monitoring by this branch of the Administration during the course of implementing the legislation.

I would have no objection to the type of board proposed by Deborah Behr for the Department of Health and Social Services, if the board is advisory in nature. However I think such a board is undesirable, for several reasons:

1. The legislature and Governor currently show little enthusiasm for the creation of additional boards and commissions.

2. It is difficult to recruit lay or "ou side" members to serve on boards of this type.

3. The board as proposed would not have expertise in the critical area: knowledge of the education and training of optometrists vis a vis drug usage.

4. The board composition as proposed includes members (ophthalmologist, Department representative) who represent groups that have testified in favor of legislation far more restrictive than would seem necessary, considering the educational background of optometrists and the track record of boards and practitioners in other states (copy of West Virginia report attached). Thus the board's deliberations would more likely be political than technical in nature.

On the other hand, I can see considerable merit in the proposal given above. The Director of Public Health could use such consulting resources as he deemed valuable. For its part, the Board of Examiners would consult with the deans and certain faculty members of the optometry schools, for they are the only ones who really know what is going on in optometric education!

I am sending to Chairman Parr this date, other possible restrictive amendments which we would regard as compromise positions. You might wish to consider them along with those suggested in this letter. Once again, I appreciate your efforts to achieve an equitable compromise, though I fear the two sides are so far apart that this will not be possible.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
Member, Board of Examiners
in Optometry
Co-Chairman, Legislative Committee,
Alaska Optometric Association

PWB/lr

enclosure

cc: Senator Charles H. Parr

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

March 13, 1981

Ms. Rocky Weller
Legislative Assistant to
Senator Charles Parr
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Ms. Weller:

Representative Don Clocksin told me on March 11 that he would like to attend the markup session for SB 136.

Perhaps you could check to see whether he has been informed of the date.

Thank you.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D.

Copies members
SB 136

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

March 6, 1981

The Honorable Charles H. Parr
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

re: SB 136

Dear Senator Parr:

Thank you for sending me for comment, the compromise proposed by the ophthalmologists. We are willing to make reasonable compromises, and several features of this proposal are acceptable to us.

Here is our response to specific points. I have numbered some paragraphs for reference, corresponding to the numbers below.

1. (Drugs allowed)

The two drugs allowed are a tiny fraction of what the schools prepare undergraduates and existing practitioners to use. Specifying individual drugs in the statute creates an obsolescence problem. [redacted] (I would suggest that since this is a detail of implementation, the statute would be less cluttered if the mandate is placed in a letter of intent to accompany the legislation, if this is appropriate for a letter of intent. The Board would follow the directives of the letter of intent.)

2. (Approval of changes in medications by joint concurrence of Optometry and Medical boards)

The Medical Board has opposed drug usage by optometrists in the past. Their involvement would create a 1 to 1 tie, and no change could be made. This is like sending the fox to guard the hen house.

3. (Required training)

Acceptable. One note on cardiopulmonary resuscitation and emergency training: This is taught by many optometry schools even though practitioners are unlikely ever to need it in their practices. I think it is a good thing for every citizen to know. However, graduates who have not had the training should have the

option of taking it in Alaska, such as a Red Cross approved CPR course.

4. (Examination by committee of 2 optometrists and 2 ophthalmologists)

A better system already exists: the schools test the students in their courses. Then the applicant must pass the Board of Examiners in Optometry examination. The Alaska board would use the pharmacology section of the National Boards, an excellent examination constructed from test questions submitted by faculty members of the schools and colleges of optometry, including pharmacologists and ophthalmologists.

5. (Mandatory referral based on single signs and symptoms)

Optometrists in Alaska make literally hundreds of referrals to ophthalmologists and other health care practitioners each year. But this proposal would result in many times that number in needless referrals. Here are some examples:

1A (Less than 20/30 vision for children under 8) - such lower acuity is the norm for preschoolers. Slataper (1950) found the average 5 year old to have 20/32 visual acuity. Weymouth (1963) found 10% of 6 year olds to have 20/36 or less. (Citations available on request). Where visual reduction is due to amblyopia, visual therapy, usually patching, takes up to 3 months or longer to show improvement, not 2 weeks.

1B Spots (floaters) in front of the eyes are normal but often are noticed suddenly, especially by people over 40. They may be pathological (as in uveitis) but this requires corroboration by other signs and symptoms. Scintillating images or flashing lights followed by headache are the classic migraine syndrome. This is untreatable except for possible pain medication.

1E Diplopia after a head blow is not uncommon and usually needs only to be monitored for improvement over the next few days and weeks.

2A Inflammation, injection can easily be treated by the optometrist with antibiotic or anti-inflammatory medications; much of this would not need to be referred if the present bill passes.

2B Corneal opacities can be old foreign body scars, long since forgotten (or never known) by the patient. We see lens opacities in developing cataract years before the cataract becomes dark enough to require removal. We usually make notes but do not always tell the patient so he will not be unduly alarmed.

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CATARACT

A cataract is an opacification of the lens or its capsule. By this definition, almost every adult has cataracts in the sense that some fine opacities are usually visible with the slit lamp in every adult lens. It is advisable, therefore, to restrict the use of the term "cataract" to opacities of the lens that materially interfere with vision. Even in the early stages of cataract, when vision is somewhat interfered with, it is probably wiser to tell the patient that he has lens opacities, rather than use the term cataract. If he asks whether this means that he is going to develop cataracts, he can be told that many times such lens opacities do not progress but remain stationary and occasionally even absorb. If they do progress and cut down his vision further, he can then be told he has a cataract. Many patients go the rest of their lives with slight impairment of vision caused by early cataracts that never increase to the point requiring an operation.

Causes of Opacification of Lens Fibers

Cataract is a loss of transparency of the lens, developing as the result of altered physical and chemical processes in its colloids. Anything which

Frances Heed Adler, Textbook of Ophthalmology, Philadelphia W B Saunders Co., 7th ed. Reprint, 1962, p. 315

2C A high cup/disc ratio is meaningless as an indicator of the need to begin glaucoma treatment unless it is corroborated by high intraocular pressure or change in the visual fields, both of which are ready optometric test procedures.

4B Tension value of 22 mm is arbitrary and, in my opinion, far too conservative, particularly when the air puff tonometer (which tends to read high) is used. Other factors, such as family history, optic cup appearance, diurnal variation and visual fields must be taken into account before deciding whether this level of tension is even marginally significant.

I hope the fallacy of requiring referral on the basis of single symptoms is readily apparent from this. To reach a diagnosis, final or even tentative, usually requires that several factors be considered in combination. One item alone is rarely meaningful. Not only would this propo al result .n great numbers

of unnecessary referrals, but it would rob the highly trained professional person of his judgment. This is the real motive of ophthalmology in proposing this as a feature of a "compromise". For if they get the law to strip optometry of its professional judgment, they can begin to bring optometry under their control and eventually eliminate it as an independent profession.

Such a mandatory referral proposal has not passed in any state, though the ophthalmologists have tried. (Utah does have one that comes uncomfortably close to this). One of our ODs said in all seriousness that if this proposal should become law he would leave Alaska. If by some chance it passed, we would probably resort to the courts.

Virtually the same document was proposed by the ophthalmologists last year. They are not truly negotiating when they introduce completely new considerations that they know we cannot possibly accept, then say, "See, they aren't willing to compromise." A compromise cannot be one step forward and two steps backward.

However since I know you are all under pressure, we have developed a wording for a mandatory referral clause that we can live with, and can use as a compromise if necessary:

> Al optometrists licensed under this chapter shall assist their patients in whatever manner possible in obtaining further care when in the professional judgment of the optometrist, the services of another health care practitioner are required. The practitioner to whom the patient is referred shall return the patient to the referring doctor with a detailed report of his findings and treatment.

This is not palatable, because it implies that we have done something wrong which requires such a statement. But at least it preserves the practitioner's discretion as to when and to whom he refers his patients. As a logical extension, it should be made to apply to general physicians as well, since they know far less about the eye and its diseases than optometrists do (see attached copy of Dr. Maumenee's remarks and the optometry-medical school comparisons in a booklet previously submitted).

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
Co-Chairman, Legislative Committee,
Alaska Optometric Association
Member, Board of Examiners

PWB/lr

Attachment

Chairman's Address

The Educational and Political Structure of Ophthalmology in America

A. Edward Maumenee, MD, Baltimore

THE SOCIOECONOMIC structure under which medicine is now practiced is in the process of one of its greatest changes in the history of our country. In this connection, a few items of particular interest to ophthalmologists are: the medical school curriculum and the place of ophthalmology in it; the National Eye Institute; Medicare; the Hart Bill now before the Senate; and our relationship to optometry, and its effect on Resolution 77 of the American Medical Association. It is not my intent to discuss these specific problems, but rather to outline the educational and political structure of ophthalmology in this country and to offer a few suggestions regarding the management of these conditions so that we may seek the most effective avenues to voice our opinion on these matters.

The educational aspects of this discussion are included because the faculty of our medical schools exert a major influence on the development and administration of new programs. This is particularly true today, when government agencies frequently seek the advice of academicians in establishing policies in medical aid and care.

Ophthalmology is a minor specialty in undergraduate teaching. According to Duane,[1] ophthalmology has subdepartmental (division) status in over 50% of the medical schools in the United States. The time allocated to the teaching of this specialty, even when it has departmental status, is extremely short. Thus, in most schools, only 60 to 100 hours are devoted to ophthalmology during the entire four years, as compared to 300 to 900 hours in the fields of obstetrics and gynecology, pediatrics, psychiatry, surgery, and medicine. In postgraduate education, however, ophthalmology assumes much greater importance, for the three to five years spent in residency training are comparable to those of other specialties. At present, about 10% of all outpatients and inpatients seek aid because of ocular complaints.

The role of ophthalmology in postgraduate teaching will probably increase greatly in the immediate future because of Medicare. An analysis of the patients over 65 years of age who received medical attention at The Johns Hopkins Hospital showed that 20% sought assistance because of ocular problems. A review of all discharge diagnoses at Hopkins on patients of any age revealed that cataract discharges were the

Submitted for publication June 20, 1966.

From the Wilmer Institute, Johns Hopkins Hospital, Baltimore.

Chairman's Address read before the Section on Ophthalmology at the 115th Annual Convention of the American Medical Association, Chicago, June 26-30, 1966.

Reprint requests to the Johns Hopkins Hospital, 601 N Broadway, Baltimore 21205 (Dr. Maumenee).

Opposition
SB 136

Dennis A. Swarner, O.D.
Robert D. O'Connell, O.D.
Doctors of Optometry
Drawer 4370
Kenai, Alaska 99611

Telephone (907) 283-7575

March 3, 1981

Mr. Charlie Parr
Pouch V
Juneau, Ak 99801

Dear Mr. Parr,

I am writing in support of Senate Bill #136. I hope you will judge this bill on it's own merits as well as the needs of the Alaskan citizens.

As a practicing Alaska Optometrist I could fill reams of paper in support of this bill but I'm sure that you are just as tired reading about the pros and cons of this bill as I am tiring of writing in it's support!!

I have a very simple solution to the problem. There are three states (Florida, North Carolina and West Virginia) that have allowed Optometrists to use the full range of Ophthalmic Drugs for several years. Look at the Optometric record relative to drug use in those states and judge accordingly.

I'm not sure how many of you folks are aware of the enormous amount of money generated by insurance companies, they usually have things pretty well figured out. Malpractice insurance for Optometrists went down nationwide last year. I'm sure not too many other professions experienced a similar reduction.

Thank you

Robert D. O'Connell, O.D.

RO/mw

Opposed to SB 136

KNOX N. CHRISTIE, D.D.S.

March 5, 1981

Representative Fred Zharoff,

I support the optometry bill # 136. Having practiced dentistry in Kodiak for seven years, it would seem helpful to the public to have minor eye problems treated by the optometrist. We have no resident opthalmologist here and the optometrists may be as well qualified to treat some problems topically, as are the local physicians. I particularly support the use of topical diagnostic drugs by the optometrist.

Sincerely,

Knox N. Christie D.D.S.

C.C. Senator Charles Parr ✓
Representative Don Clocksin
Senator Bob Mulcahy

POST OFFICE BOX 801 KODIAK, ALASKA 99615 TELEPHONE 907-486-3291

members files
SB 136

The ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PROFESSIONAL PERSPECTIVES No. 1

AETNA REDUCES ANNUAL PREMIUM FOR INSURED AOA MEMBERS

Hartford, CT--More than two years of efforts between the American Optometric Association and Aetna Life & Casulty Co. have prompted the Hartford based insurance firm to REDUCE PROFESSIONAL LIABILITY RATES FOR AOA MEMBERS BY 18 PERCENT. The high quality of professional vision care which AOA optometrists are providing has warranted this reduction. Fear expressed by ophthalmologists, in those states which allowed optometrists to use ophthalmic drugs, was unfounded. Optometry has been the ONLY major health care profession to have its liability insurance rates reduced.

KNOX N. CHRISTIE, D.D.S.

March 5, 1981

Senator Charles Parr,

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Sincerely,

Knox N. Christie D.D.S.

C.C. Representative Fred Zharoff
Representative Don Clocksin
Senator Bob Mulcahy

POST OFFICE BOX 801 KODIAK, ALASKA 99615 TELEPHONE 907-486-3391

Copies members
SB 136

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

March 6, 1981

The Honorable Charles H. Parr
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

re: SB 136

Dear Senator Parr:

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Here is our response to specific points. I have numbered some paragraphs for reference, corresponding to the numbers below.

1. (Drugs allowed)

The two drugs allowed are a tiny fraction of what the schools prepare undergraduates and existing practitioners to use. Specifying individual drugs in the statute creates an obsolescence problem. We can accept a compromise that specifies certain classes of diagnostic and therapeutic drugs in the statute. We can also accept mandated ophthalmological consultation in determining, by regulation, which drugs within each class may or may not be used. (I would suggest that since this is a detail of implementation, the statute would be less cluttered if the mandate is placed in a letter of intent to accompany the legislation, if this is appropriate for a letter of intent. The Board would follow the directives of the letter of intent.)

2. (Approval of changes in medications by joint concurrence of Optometry and Medical boards)

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5. (Mandatory referral based on single signs and symptoms)

Optometrists in Alaska make literally hundreds of referrals to ophthalmologists and other health care practitioners each year. But this proposal would result in many times that number in needless referrals. Here are some examples:

1A. (Less than 20/30 vision for children under 8) - such lower acuity is the norm for preschoolers. Slataper (1950) found the average 5 year old to have 20/32 visual acuity. Weymouth (1963) found 10% of 6 year olds to have 20/36 or less. (Citations available on request). Where visual reduction is due to amblyopia, visual therapy, usually patching, takes up to 3 months or longer to show improvement, not 2 weeks.

1B Spots (floaters) in front of the eyes are normal but often are noticed suddenly, especially by people over 40. They may be pathological (as in uveitis) but this requires corroboration by other signs and symptoms. Scintillating images or flashing lights followed by headache are the classic migraine syndrome. This is untreatable except for possible pain medication.

1E Diplopia after a head blow is not uncommon and usually needs only to be monitored for improvement over the next few days and weeks.

2A Inflammation, injection can easily be treated by the optometrist with antibiotic or anti-inflammatory medications; much of this would not need to be referred if the present bill passes.

2B Corneal opacities can be old foreign body scars, long since forgotten (or never known) by the patient. We see lens opacities in developing cataract years before the cataract becomes dark enough to require removal. We usually make notes but do not always tell the patient so he will not be unduly alarmed.

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CATARACT

A cataract is an opacification of the lens or its capsule. By this definition, almost every adult has cataracts in the sense that some fine opacities are usually visible with the slit lamp in every adult lens. It is advisable, therefore, to restrict the use of the term "cataract" to opacities of the lens that materially interfere with vision. Even in the early stages of cataract, when vision is somewhat interfered with, it is probably wiser to tell the patient that he has lens opacities, rather than use the term cataract. If he asks whether this means that he is going to develop cataracts, he can be told that many times such lens opacities do not progress but remain stationary and occasionally even absorb. If they do progress and cut down his vision further, he can then be told he has a cataract. Many patients go the rest of their lives with slight impairment of vision caused by early cataracts that never increase to the point requiring an operation.

Causes of Opacification of Lens Fibers

Cataract is a loss of transparency of the lens, developing as the result of altered physical and chemical processes in its colloids. Anything which

2C A high cup/disc ratio is meaningless as an indicator of the need to begin glaucoma treatment unless it is corroborat d by high intraocular pressure or change in the visual fields, both of which are ready optometric test procedures.

4B Tension value of 22 mm is arbitrary and, in my opinion, far too conservative, particularly when the air puff tonometer (which tends to read high) is used. Other factors, such as family history, optic cup appearance, diurnal variation and visual fields must be taken into account before deciding whether this level of tension is even marginally significant.

I hope the fallacy of requiring referral on the basis of single symptoms is readily apparent from this. To reach a diagnosis, final o. even tentative, usually requires that several factors be considered in combination. One item alone is rarely meaningful. Not only would this proposal result in great numbers

of unnecessary referrals, but it would rob the highly trained professional person of his judgment. This is the real motive of ophthalmology in proposing this as a feature of a "compromise". For if they get the law to strip optometry of its professional judgment, they can begin to bring optometry under their control and eventually eliminate it as an independent profession.

Such a mandatory referral proposal has not passed in any state, though the ophthalmologists have tried. (Utah does have one that comes uncomfortably close to this). One of our ODs said in all seriousness that if this proposal should become law he would leave Alaska. If by some chance it passed, we would probably resort to the courts.

Virtually the same document was proposed by the ophthalmologists last year. They are not truly negotiating when they introduce completely new considerations that they know we cannot possibly accept, then say, "See, they aren't willing to compromise." A compromise cannot be one step forward and two steps backward.

However since I know you are all under pressure, we have developed a wording for a mandatory referral clause that we can live with, and can use as a compromise if necessary:

> All optometrists licensed under this chapter shall assist their patients in whatever manner possible in obtaining further care when in the professional judgment of the optometrist, the services of another health care practitioner are required. The practitioner to whom the patient is referred shall return the patient to the referring doctor with a detailed report of his findings and treatment.

This is not palatable, because it implies that we have done something wrong which requires such a statement. But at least it preserves the practitioner's discretion as to when and to whom he refers his patients. As a logical extension, it should be made to apply to general physicians as well, since they know far less about the eye and its diseases than optometrists do (see attached copy of Dr. Maumenee's remarks and the optometry-medical school comparisons in a booklet previously submitted).

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
Co-Chairman, Legislative Committee,
Alaska Optometric Association
Member, Board of Examiners

PWB/lr

Attachment

Copies mem bers
SB 136

Dennis A. Swarner, O.D.
Robert D. O'Connell, O.D.
Doctors of Optometry
Drawer 4370
Kenai, Alaska 99611

Telephone (907) 283-7575

March 3, 1981

Mr. Charlie Parr
Pouch V
Juneau, Ak 99801

Dear Mr. Parr,

I am writing in support of Senate Bill #136. I hope you will judge this bill on it's own merits as well as the needs of the Alaskan citizens.

As a practicing Alaska Optometrist I could fill reams of paper in support of this bill but I'm sure that you are just as tired reading about the pros and cons of this bill as I am tiring of writing in it's support!!

I have a very simple solution to the problem. There are three states (Florida, North Carolina and West Virginia) that have allowed Optometrists to use the full range of Ophthalmic Drugs for several years. Look at the Optometric record relative to drug use in those states and judge accordingly.

I'm not sure how many of you folks are aware of the enormous amount of money generated by insurance companies, they usually have things pretty well figured out. Malpractice insurance for Optometrists went down nationwide last year. I'm sure not too many other professions experienced a similar reduction.

Thank you

Robert D. O'Connell, O.D.

RO/mw

Copy, Minutes
SB 136

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

March 4, 1981

The Honorable Charles H. Parr
Chairman, Senate Health, Education
and Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

In accordance with your request at the February 27 hearing on SB 136, I am enclosing a list of the types of ophthalmic drugs that optometrists believe should be permitted under SB 136. The list represents those categories of drugs whose clinical use is taught by the Pennsylvania College of Optometry.

When contacted about the preparation of this list, the Academic Dean of Pennsylvania College indicated that a full listing of drugs under each category would be unduly long and cumbersome, and he suggested instead that a few examples of each category be included; this they have done. I might note that the examples given are generic names and that two or more companies may market the same generic product under different brand names. A comprehensive listing of drugs in each category is available in the Physicians Desk Reference for Ophthalmology. I can provide this information on request.

Since drugs are constantly changing and improving, it appears that writing specific drugs into the statute would subject the statute to rapid obsolescence. We would prefer to have the Board of Examiners authorize drugs by regulation, using such consulting resources as it deems necessary. However an acceptable intermediate position would be to specify in the legislation, categories of drugs, which are unlikely to change with time.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
Member, Board of Examiners
in Optometry

PWB/lr

Enclosure

1200 West Godfrey Avenue
Philadelphia, Pa. 19141
215 424 5900

Office of Academic Affairs

Pennsylvania College of Optometry

The Eye Institute
1201 West Spencer Street
Philadelphia, Pa. 19141
215 276 6000

March 3, 1981

Phillip W. Bach, O.D., Ph.D.
Suite 204
Denali Professional Center
3401 Denali Street
Anchorage, Alaska 99503

Dear Doctor Bach:

In response to your reques. I have formulated a list of pharmaceutical agents which may be helpful in preparing your legislation. The current graduating class from the Pennsylvania College of Optometry has developed competency in utilizing pharmaceutical agents in the various catagories and classifications listed below.

Currently the students at the College develop a theoretical knowledge of these pharmaceutical agents through various didactic courses, and expertise in the clinical utilization of these drugs through a variety of clinical experiences. These clinical experiences occur in various settings such as The Eye Institute of the Pennsylvania College of Optometry, Veterans Administration Medical Centers, Health Maintenance Organizations, Armed Forces Hospitals, and private practice settings.

A major emphasis of the curriculum at the College is the di ential diagnosis of ocular diseases and systemic diseases with ocular complications. We feel the critical step in the management of ocular and visual disorders is the specific differential diagnosis. The application of pharmaceutical agents is simply one of the competencies necessary in the continuum of the diagnosis and management of ocular diseases.

Listed below are the major classifications and catagories of pharmaceutical agents commonly utilized in the patient care setting of the College. Examples are given of different drugs in each catagory. This is not to be interpreted that other drugs within these catagories are not utilized when specifically needed, based on the professional judgements of the clinician.