ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1477 SHESS SB 136 (#2) (47)

I. Topical Anesthetics
   Example: Proparacaine
   Benoxinate

II. Mydriatics
   A. Sympathomimetics
      Example: Phenylephrine
   B. Parasympatholytics
      Example: Atropine group

III. Cycloplegics
   A. Parasympatholytics
      Examples: Atropine group
      Cyclopentolate

IV. Miotics
   A. Examples: Pilocarpine
      Anticholinesterases

V. Antimicrobials
   A. Antibioltics
      Examples: Tetracycline
      Erythromycin
      Gentamicin
      Chloramphenicol
      Bacitracin
      Cephalosporins
   B. Antibacterial
      Example: Sulfonamides
   C. Antiviral
      Example: Idoxuridine
   D. Antifungal
      Example: Natamycin

VI. Anti-inflammatory
   Example: Corticosteroids

VII. Anti-glaucomma
   A. Sympathomimetics
      Example: Epinephrine
   B. Sympatholytic
      Example: Timolol Maleate
   C. Parasympathomimetics
      Examples: Pilocarpine
      Anticholinesterases
   D. Carbonic Anhydrase Inhibitors
      Example: Acetazolamide

VIII. Antihistamines
Examples: Diphenhydramine
Antazoline

IX. Miscellaneous Legend Drugs
Example: Hyperosmotic Agents

X. Over-the-counter Drugs
Example: Dyes
Ocular Lubricants
Decongestants

I hope this list is of some help to you in constructing your new legislation. The Pennsylvania College of Optometry stands prepared to assist you educationally in meeting the visual care needs of the people of Alaska.

Sincerely,

Thomas L. Lewis, O.D., Ph.D.
Dean of Academic Affairs

TLL:dmf

NORTH PACIFIC MEDICAL CENTER
P. O. BOX 948
KODIAK, AK 99615
TELEPHONE (907) 486-4163

RON BROCKMAN, D. O.
ORTHOPAEDIC SURGERY
RICHARD HOLYOKE, PA-C

LOREN HALTER, D. O. (D.A.B.F.P.)
FAMILY MEDICINE
GARY HURLBURT, PA-C

March 6, 1981

The Honorable Charles H. Parr
Health, Education and Social
Services Committee
Pouch U
Juneau, Alaska 99811

Dear Senator Parr,

The passage of Senate Bill 136 (House Bill III) will help to provide better and more prompt health care for the population of Alaska.

We often use our local optometrist for consultation, diagnosis, and treatment of eye related problems. Many times he is called into the hospital for consultation. It is more effective to use his knowledge and instrumentation to determine whether a patient has a minor eye disease or something more serious. He is better equipped to handle their problem, and to treat those problems within his realm of expertise, and give the necessary follow-up care.

It is an unnessary expense and inconvenient for the patient to go back and forth from one office to the other, when these problems can be handled by the optometrist.

Also, here in Kodiak, there is a close relationship (because of our distance from a large referral center) between ourselves and the optometrist, in order that we may give better mdical care.

NORTH PACIFIC MEDICAL CENTER

LOREN D. HALTER, D.O.

RON BROCKMAN, D.O.

GARY HURLBURT, PA-C

RICHARD HOLYOKE, PA-C

cc: Rep. D. Clocksin Chairman House HESS
Rep. Fred Zharoff
Sen. Bob Mulcahy

Copies members
SB 136

TELEGRAM

ALASCOM, INC.
PHONE: 586-6442
JUNEAU, AK 99802

#

02151 ANCHORAGE ALASKA 70 03-10 1245P AST

PMS SENATOR CHARLES PARR, CHAIRMAN HESS COMMITTEE

ALASKA STATE SENATE ROOM 209 BEHRENDS BLDG

JUNEAU AK 99811 920)

URGE YOU NOT USE DEPARTMENT OF HEALTH AND SOCIAL SERVICES PROPOSED SUBSTITUTE FOR SB36 AS THE VEHICLE FOR MARKUP. IT PERMANENTLY REMOVES ALL CONTROL OF DRUGS FROM THE BOARD OF EXAMINERS, ALLOWS FOR NO POSSIBILITY OF THERAPEUTIC USAGE, NOW OR IN THE FUTURE, AND EVEN REMOVES THE WORD DIAGNOSIS FROM THE EXISTING DEFINITION OF OPTOMETRY. WITH THE ORIGINAL BILL THERE IS ROOM FOR COMPROMISE IF NEED BE.

PHILLIP W BACH, O.D.

COCHAIRMAN LEGISLATIVE COMMITTEE

ALASKA OPTOMETRIC ASSOCIATION

Copy of written
SB 136

DR. CURTIS M. JOHNSON
OPTOMETRIST
530 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701

Telephone 456-4010

March 6, 1981

Senator Charlie Parr
Pouch V
Juneau, Alaska 99811

Dear Senator Parr;

This is in response to a proposed compromise subatitute for SB 136.

This is no compromise at all, it is all take and no give, more commonly known as R & R (rape and run).

1. Drug list offered is too restrictive with too many strings attached and too cumbersome to change as new and better drugs appear.

2. It would result is massive needless referrals as most conditions listed are not pathological and the ones that may be are presently referred already. It would destroy the professional judgement of the optometrist.

3. It appears a clever ploy to prevent further development of our profession. If something like this were to pass their next step would be legislation to require all patients to have ophthalmological evaluation for pathology before they could be seen by an optometrist. This would wipe out our profession which is really what they want, despite their protestations.

4. This would set a dangerous precedent for other professions such as dentistry, phycology, etc.

5.. The general MD would be exempt from these provisions and most everyone seems to agree that the optometrist knows more about the eye than the general practicioner.

If a true and sincere compromise were offered maybe something could be worked out but this is a sham and smokescreen.

Sincerely,

Curtis M. Johnson, O.D.

memory

J. L. BEASON CO.
P. O. BOX 810
JUNEAU, ALASKA 99802
907 / 586-2238

March 6, 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 seek your committee's support for Senate Bill 136.

It is my understanding that optometrists cannot so much as treat a pink eye because ophthalmolgists wish to protect themselves from every shred of competition. This can only result in higher costs and longer times waiting for an appointment.

Recently an optometrist sent me to an ophthalmologist for an internal condition of my eye so I am familiar with both professions. We, the public, cannot benefit if one group is not allowed to fully use its skills and knowledge.

Very truly yours,

Jerry Beason

cc: Senator Bill Ray

SB 136 file

EYE, EAR, NOSE & THROAT CLINIC

1919 LATHROP — FAIRBANKS, ALASKA 99707 — PHONE: 456-7767

MESSAGE

TO Hon. Ken Fleming
Pouch V
Juneau, AK 99811

DATE: 2/13/81

Optometric Legislation

Thanks for the latest handout by optometry - Here are 5 quick passes from W.Va.
The sad sad thing is no one knows the real number of missed diagnoses and improper treatment percentages.
Thanks again,

Sam

BY

REPLY

DATE: 2/24

Sam -
Thanks so much for your response - I'll make certain the info gets to the right folks - I'm preparing now a rather lengthy correspondence on the overall issue - appreciate your patience & cooperation -

BY

ADDRESSEE: Keep this Copy for your files

The
ALASKA OPTOMETRIC ASSOCIATION
AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PROFESSIONAL PERSPECTIVES No. 2

OPHTHALMIC DRUG USE REPORT BY WEST VIRGINIA

Since 1976 certified optometrists in West Virginia have administered ophthalmic drugs for diagnostic and therapeutic use. A total of sixty-three (63) different drugs prescribable for the human eye have been employed since H.B. 1005 was enacted. Thirty thousand six hundred forty-nine (30,649) individual patients have been seen by certified optometrists. The distance those patients saved by not having to travel to sparsely located ophthalmologists to whom they formally were referred was over 450,000 aggrevated miles.

Forty-six (46) different pathological conditions have been diagnosed and treated by these certified optometrists. IT SHOULD BE ADDITIONALLY NOTED THAT THERE HAS BEEN NO REPORT OF ANY ADVERSE REACTION IN THE DIAGNOSIS AND TREATMENT RENDERED TO PATIENTS INVOLVED BY ANY WEST VIRGINIA CERTIFIED OPTOMETRIST.

CRAP!
Sw.

PATIENT — (Confidential file)
STATE — West Virginia
REPORTING SOURCE — Physician (M.D.)
INFORMATION SOURCE —
Ralph W. Ryan, M.D., Morgantown, West Virginia, (THE PEN, Vol. 2, No. 4, February 15, 1978).
HISTORY — (Synopsis)

A 63-year-old female patient went to an optometrist complaining of decreased vision and watering in the right eye. Treatment in the form of drops was given.

Patient's family physician became aware of her vision loss in the right eye and referred her to an ophthalmologist. An easily seen retinal detachment was found in the right eye. Delay in necessary retinal surgery is believed to be the cause of a patient's statutory blindness in the affected eye.

CASE CLASSIFICATION— Optometric mismanagement and failure to refer.

PATIENT — (Confidential file)
STATE — West Virginia
REPORTING SOURCE — Physician (M.D.)
INFORMATION SOURCE —
Ralph W. Ryan, M.D., Morgantown, West Virginia, (THE PEN, Vol. 2, No. 4, February 15, 1978).
HISTORY — (Synopsis)

A registered nurse working on her Master's degree, felt the reading involved had caused excessive strain on her eyes and visited an optometrist. He advised the patient that she had a malignant melanoma of the iris in the left eye. The patient was advised that some 13% of the optometrist's patients had these tumors.

Greatly alarmed, the patient consulted an ophthalmologist. Examination revealed some need for eyeglasses and "freckles" in the iris of both eyes. None of the brown spots showed any indication of malignancy.

CASE CLASSIFICATION— Optometric mismanagement and failure to refer.

PATIENT — Mrs. Laura Dent
STATE — West Virginia
REPORTING SOURCE — Patient
INFORMATION SOURCE —
Richard Rashid, M.D., South Charleston, W. Virginia, (THE PEN, Vol. 3 - No. 2 - 1979)
HISTORY — (Synopsis)

A female supermarket cashier visited an optometrist in May, 1975 for a general eye examination. She was advised that there were no signs of glaucoma or other eye diseases, and new glasses were prescribed. Within two weeks, the patient's vision became distorted. She contacted the optometrist, who again examined the patient, advising that the distortion was caused by astigmatism which would be corrected by continuing to wear the glasses he prescribed.

When the condition failed to improve, the patient visited her family physician, who found serious deterioration in both eyes. She was immediately referred to an ophthalmologist. Doctors Rashid and Toma, both ophthalmologists, examined the patient and found she was suffering from histoplasmosis (a disease caused by fungus). It was found that the disease had been present for a long period of time.

After six months of treatment, the laser was used to arrest the disease. Central vision in the left eye has been destroyed and vision is limited in the right eye. She was placed on continuing observation and treatment.

CASE CLASSIFICATION— Optometric mismanagement and failure to refer.

PATIENT — D. J. Denkins
STATE — West Virginia
REPORTING SOURCE — Patient
INFORMATION SOURCE —
Richard Rashid, M.D., South Charleston, W. Virginia, (THE PEN, Vol. 3 - No. 7 - April 1, 1979)
HISTORY — (Synopsis)

A businessman reports that he visited an optometrist after developing a vision problem. Patient was told by the optometrist that he had a detached retina, a loss of sight for which nothing could be done.

Several months later, the patient suffering excrutiating pain in his damaged eye called on an ophthalmologist who discovered a tumor that required surgery and removal of the patient's eye. Failure to refer early cost the patient the loss of an eye and possibly endangered his life.

CASE CLASSIFICATION— Optometric mismanagement and failure to refer.

PATIENT — Ina Browning
STATE — West Virginia
REPORTING SOURCE — Physician (M.D.)
INFORMATION SOURCE —
Richard C. Rashid, M.D., Charleston, W. Va.
HISTORY — (Synopsis)

A 74-year-old female patient experiencing a problem with her left eye, saw an optometrist in August of 1977. He placed the patient under treatment using a salve which the patient said, "liked to put my eye out". The medication was changed and changed again on August 10, 1978, when Vasocidin was administered. Following treatment, the eye became rapidly worse with excruciating pain. On August 24, 1978, the patient saw Dr. David W. Mullins, an ophthalmologist. He found a damaged left eye, which had perforated, but brought the condition under fair control with intensive treatment.

For other medical problems, the patient was later seen by an internist at a hospital in Charleston, West Virginia, some 60 miles from her hometown. The internist there recognized a serious eye problem and called Dr. Richard C. Rashid, a Charleston ophthalmologist, to the hospital. The damaged left eye had ruptured, and the patient was immediately admitted to the hospital. Every effort was made to control infection and to find an eye donor so that a piece of cornea might be obtained to patch and possibly save the damaged eye. Surgery was undertaken on November 27, and a corneal transplant was done for therapeutic purposes. At the time this report was submitted, it appeared unlikely that vision in the patient's damaged left eye could be restored. Improper diagnosis, drug use and treatment, as well as failure to refer, caused the patient to lose sight in her left eye.

CASE CLASSIFICATION — Optometric mismanagement and failure to refer.

John — Ken says hold

FEB 17 1981

The ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

February 12, 1981

Honorable Kenneth J. Fanning
Alaska State House of Representatives
Pouch V
Juneau, AK 99811

Dear Representative Fanning:

Enclosed is the optometric drug bill HB 111 as it emerged from drafting. It differs slightly from the wording of the proposed bill in the booklet we sent you. It tightens the revision language in the pharmaceuticals statute (A.S. 17.15) to relate more closely to the existing paragraphs.

Your staff can use the bill number for filing the booklet.

Very truly yours,

Maynard Falconer, O.D.
Phillip Bach, O.D., Ph.D.
Legislative Committee

1/30/81

TELEPHONE CONVERSATION WITH DR. SAM MCCONKEY, PH # 456-7760

McConkey is an Md. physician, 12 years education after high school.

Optometry school is not a medical school. Requires only two to four years additional schooling after high school. There is not one full-time M.D. on staff at ANY school of optometry in the US.

Study done which has stated that optometry schools are simply "make work" schools. They are not associated with any medical school.

Optometrists declared themselves a profession in 1951. Now they are trying to legislate themselves into the medical profession. They are trained to fit and prescribe glasses, not make diagnosis re: drugs, etc.

Last year, Dr. McConkey met with Sen. Hackney and Coletta and two optometrists to work out a compromise in order to protect the patient. The compromise allowed optometrists to prescribe drugs, however there were safeguards. (about six or seven different points - Dr. McConkey is mailing us a copy)

The compromise was agreed to by all there. But there was no further response from the optometrists. McConkey called Falconer, who told him that there would be no compromise - "If we wait long enough, we'll get exactly what we want" (Exact quote, according to Dr. McConkey)

About 1/2 of the States now allow optometrists to prescribe drugs. However McConkey cited several examples of poor results - one boy lost his eye because after the optometrist discovered the problem which he couldn't diagnose, he would not refer him to an opthamologist. $250,000 settlement in process now.

Other countries have not found it safe to let optometrists diagnose these problems and treat them. In Great Britain - mandatory referra if vision is worse than 20/40. In Israel an optometrist is not allowed to treat anyone over 50 or under 10. In Italy - no one over 40 or under 10. Greece does NOT allow optometry.

McConkey repeatedly stated that his concern was not to keep business from the optometrists (he has enough business!), but to protect the patient and make him aware of the differences between an opthamologist and an optometrist.

FEB 2 1981

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
SAMUEL A. McCONKEY, M.D.

OPTOMETRIST
ROBERT P. HAMMOND, O.D.

OTOLARYNGOLOGIST
RONALD E. TINSLEY, M.D.
RICHARD P. RAUGUST, M.D.
BRUCE G. WHIPPLE, M.D.

AUDIOLOGIST
PHYLLIS K. CASHEK, M.A.CCC

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D., F.A.C.S.
RICHARD G. PARRY, M.D.

ORAL AND MAXILLOFACIAL SURGEON
ROBERT L. HASTINGS, D.M.D.
DENNIS W. JEFFERS, D.D.S.

ADMINISTRATOR
NICHOLAS J. NOEL

EYE, EAR, NOSE & THROAT CLINIC

1/29/81

Gail,

① The first paper is rough draft of my testimony I plan to give this year.

② The second is a synopsis letter of 2 years ago to Sen Zeigler

③ The third was my with presentation to 1979 session

④ The four " " oral presentation " "

⑤ This paper is one I talked to you about optometric training

⑥ Vs Medical — This is how family practice people do it. Optoms can do the same without drugs.

⑦ An independent study on eye drugs + use in Alaska

⑧ The compromise we came up with in Sen Colletta's office that Jakosh refused to comply with

⑨ PEN paper - Timothy Steele, the Alaska Coor Sent finally by my partner, Bruce Wolf.

Thanks, Lee

1919 LATHROP STREET P.O. BOX 74476 FAIRBANKS, ALASKA 99707 PHONE 456-7757

Ken, This is rough draft of what I plan to say @ committee hearings this session. FEB 2 19[illegible]

SL

OPTOMETRIC LEGISLATION - 1981

Ladies and Gentlemen:

Optometry has an unyielding determination to substitute legislation for medical education. If you, as the guardians of the citizen's welfare in the State of Alaska, feel this type of legislation indeed is warranted, the least you can do is offer the citizens some safeguards. After all, it is their sight and in some cases their lives we are talking about.

For the fourth year, we meet again. The question of drug use by non-physicians was well on its way toward a compromise solution last year when the representatives of the non-physician group (Roy Box and James Matson) met with myself, Robert Page, Peter Carava, and Ron Tokar, all M.D. ophthalmologists, as well as Rick Urion, who was then the Optometric Lobbyist, and Jeff Landry, the Alaska State Medical Lobbyist.

We met in good faith at the request of Senators Coletta and Hackney to find a fair and reasonable compromise to this legislative bag of worms. The compromise was reached and agreed to by all, with the understanding that the participants spoke for their respective groups. After all of us had a typed copy of our agreement, I had no further response from the Optometrists. I called Falconer, the optometric power in Anchorage, and was told that there was no way they would agree to any compromise, at which time he stated, "All we have to do is wait long enough and we will get everything we want". As you might imagine, that was the end of any negotiating. It was certainly disappointing to have the group who initially put this type of legislation before you, say with such finality that they were not interested in any compromise. The Optometric motives must be questioned.

It has been repeatedly stated to previous committee members that the optometric intent is not to eventually practice medicine, but only to increase the capacity to diagnose eye problems because of their legal liability. If that is so, then why does the most prominent optometric spokesman, Henry Peters, O.D. have his stationery headed by the words "Optometric Medicine" "General Practice" and why does the group which Dr. Peters heads call itself the "American College of Optometric Physicians" and why have he and the dean of the Southern College of Optometry taken it upon themselves to redefine optometrists as: " a physician who practices optometry" and why do they redefine optometry as: "that branch of the science and art of medicine dealing with the treatment and prevention of disorders and maintenance of health of the human eye and visual system" and why are they promoting the title "doctor of optometric medicine". The truth is that prior to 1951, there was not even an O.D. degree (Dr. of Optometry) known to man and the optomerrists confered this degree upon themselves.

If the intent is not to practice medicine, then why do they hold "seminars" in the management of ocular emergencies, management of specific neuro-ophthalmic disorders, the management of peripheral retinal disorders. Some of these conditions are purely in the realm of the neurologist - neurosurgeon and are not in the purvue of even eye physicians and surgeons.

At this juncture, it serves no useful purpose to go back and rehash all the previous arguments relating to the inappropriateness of this type of legislation (to make someone a pseudophysician by legislative fiat, the hazards of drug use, ary drug use, and most especially the general overall lack of training needed to be a diagnostician as concerns the visual apparatus).

There is no conceivable way that optometry approaches the intensity, duration, exposure, or depth that is required in medical training.

Recent publications (Optometric Management, December 1980) recommend withholding referrals from an ophthalmologist if politically the physician does not support this optometric intrusion into medicine. This is abhorent to me.

The first rule of medicine is "Do no harm". Withholding appropriate care to any deserving patient demonstrates an apalling lack of moral and professional ethics and will not be tolerated by the public under any circumstances. Any group who participates in such a conspiracy does not only not deserve to be called "doctor" of anything, but should not be allowed access to the public.

The governments of several countries have taken steps to see this sort of thing does not endanger their citizens. Recently, the Ministry of Health of Israel signed an order which prohibits optometrists from examining anyone under the age of 10 or over the age of 50 without an ophthalmology referral. Italy's law is similar. Optometrists can only examine anyone between the age of 10 and 40 without ophthalmologic referral. In Greece, the practice has been outlawed totally.

The picture is now in perspective.

I am tired of coming back here year after year.

I am tired of taking up your time with an issue that should not even be before you.

I am embarassed that I have become involved with this debasing, and degrading, unethical group of non-physicians.

I am disillusioned with the lack of ethics on the part of this group who have distorted and mis-represented themselves.

I have not been impressed with the attitude of the lower house of the legislature when considering this question. Turf bill, indeed - What shallow thinking!

I am a professional. I have spent too many years being educated so that I can provide an ethical, professionally rewarding, and morally fulfilling service to my patients to continue this.

The minimum safeguards acceptable, in my opinion, would be those outlined in the previously accepted compromise. This gives Optometry more legal safeguards than they should ever expect and certainly more than any real physician in real medicine could ever hope to obtain. As a physician at risk every time I see a patient, I would certainly like to be absolved of all responsibility if all I had to do was follow the suggested criteria. However, I am not so naive as to think this will ever come to pass. I accept the responsibility. My training and experience gives me that confidence, not the conferring of some quasi-medical degree by a State Legislature.

FEB 2 19

OPHTHALMOLOGIST
WILLIAM F KINN M D
BRUCE L WOLF, M D
SAMUEL A McCONKEY, M D

OTOLARYNGOLOGIST
RONALD E TINSLEY M D
RICHARD P RAUGUST, M D
BRUCE G WHIPPLE, M D

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W WENNEN M D

EYE, EAR, NOSE & THROAT CLINIC

May 22, 1978

Senator Robert Ziegler
Capitol Room 211
Juneau, Alaska 99811

Dear Senator Ziegler:

I understand that House Bill 664, an act relating to optometry, that recently passed the House with a three vote margin has been referred to your committee. I hope you can take a few moments to read this brief summary of what I feel are the important points to consider in this legislation.

This bill, if passed, would give optometrists (nonphysicians) the power to use "diagnostic drops" in the eyes of their customers. This legislation that you have before you is part of a nationwide effort on the part of organized optometry to introduce themselves into the field of medicine. Early on, optometry passed this bill in eight states before the medical profession was aware of their concerted efforts. However, the second year that this was introduced, this legislation was defeated in 14 states and only passed in four. In 1978, the legislation has been defeated in ten states and has only passed in two. The trend is clear, and that is, that once an informed legislature and public are aware of this type of legislation, it has been defeated overwhelmingly in legislatures across the country. The bill is not good for the public welfare and, in fact, endangers them at the hands of nonphysicians. Allow me to make several points then, and they are as follows:

1. As concerns "diagnostic drops." The general nomenclature is certainly a misnomer. These drugs are only called "diagnostic drops" by optometrists and not by physicians. Drops do not diagnose, people diagnose, and only people with the proper education, training, and experience to make these determinations should be allowed to use them. Currently, physicians who have completed their academic and clinical training have this ability and optometrists have minimal classroom training and no clinical experience with patients in the use of these medications.

2. Dilating the eye is not a prerequisite to making a diagnosis of eye disease, dilating drops are not a prerequisite to supplying children with the proper glasses correction, and anesthetic drops are not needed for tonometry or the presumptive diagnosis of glaucoma.

3. It has been said in several states that have passed this legislation that because of the maldistribution between optometrists and ophthalmologists (physicians) that optometry could provide care where no other care was available. The status in Alaska is that there is no maldistribution between those that have the concern for providing eye care to our residents. The state is equally well covered by both optometry and ophthalmology.

1919 LATHROP STREET P O 1248, FAIRBANKS, ALASKA 99707, PHONE 456-7767

4. Alaska is a unique state in that there is a high incidence of narrow angle glaucoma in the residents in Alaska, particularly among the native population. Narrow angle glaucoma is a severe high pressure in the eye that is caused by dilating the eye, specifically caused by the drops that the optometrists want to be able to use. This is a surgical disease, and the potential for inducing this problem should not be legislated on nonphysicians.

5. It's quite important that anyone involved with the use of medications in any fashion be capable of handling any systemic or local reactions to the medication, no matter how uncommon they may be. Optometrists have absolutely no training or preparation in the management of these potentially serious and, in some cases, life threatening reactions that happen occasionally with the use of these drops.

6. It should be mentioned that ophthalmology has no financial interest in this type of legislation and, as a matter of fact, this is not special interest legislation in any sense of the word. Ophthalmology is responding because we are the best qualified people to ask for an opinion and because we feel it is absolutely detrimental to the public's welfare.

7. Consumer protection is quite prominent in all of our considerations. It's evident from the efforts in other parts of the United States that optometry is lobbying both in the public sphere and in the legislatures across the country to be the primary eye care provider across the United States. It's my contention that this further confuses the public as to who they are seeing for their eye care. This does not give them any advantage. I can substantiate several cases of patients thinking they were being seen by an eye physician and, in truth, were being seen by an optometrist which, in some cases, has resulted in malpractice suits against optometrists for delays of diagnosis of potentially quite serious disease.

8. It would seem that of all the people available for comment, it would be those people who are both optometrists and ophthalmologists. I refer you to Dr. Roger L. Hiatt, M.D., who is a former optometrist and now a physician, Chairman of the Department of Ophthalmology at the University of Tennessee College of Medicine in Memphis. He is adamantly opposed to this type of legislation, having been through both training programs.

Thank you very much for your time in reading this brief summary. I would hope that you will have an opportunity to peruse other material and copies of data that have been sent to the HESS Committee in the House.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

February 14, 1979

FEB 2 1981

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   d. There should be no grandfather clause.

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

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

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

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

Thank you for the time you have taken.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

FEB 2 1981

Outline Comments for Senate Meeting with Optometry

February 11, 1980

I. INTRODUCTION

Once again, for the third year in a row, I am embarassed to be here. I do not think this is the proper forum for a discussion of this topic. The Legislature has been placed in an untenable position trying to decide on professional standards and it is unfortunate indeed that you have been forced to go through this procedure. I must say that we have tried on numerous other occasions to meet with some of the responsible members of Optometry to discuss this question, and those attempts were to no avail. Unfortunately, here we are again forcing you to waste time on a subject that should not even be presented to you. I honestly feel that the Legislature and its members have more important questions before them that decide the future of our state, not only financially but philosophically, and that your time should not be spent on what is considered by many of the legislators to be a turf bill. The truth is that Ophthalmology did not introduce this legislation, Optometry did, to further their own interests in lieu of the accepted mechanisms for raising ones position in the medical community, i.e. by being medically educated by qualified instructors to insure that the public will be protected.

Unfortunately, Optometry has elected not to pursue this path but would prefer, by legislative fiat, to enjoy the benefits of being a physician without the appropriate background and training. Dr. Roger Hyatt, Chairman of the Department of Ophthalmology at the University of Tennessee is also an Optometrist who elected to go to Medical School and become an ophthalmologist. I would like to present his comments briefly, and I quote:

Optometry's arguments (in this sort of legislative effort) overlook two great dangers. First, the public in general associates the use of drugs with medically trained people, which Optometrists are not. Accordingly, when one applies medicine to the eye and attempts to present to the patient the ability to diagnose disease, he is putting himself legally, ethically, morally, and educationally in a position he is unable to assume as an Optometrist. Not only are Optometrists incapable of using equipment necessary to study disease, but they are unable to interpret what they might see. No one without proper medical training, including medical school, internship, and residency, can set himself up as an eye specialist capable of diagnosing disease. In fact, diagnosis is the practice of medicine. Diagnosis, not therapy, is the most difficult task facing the eye specialist today. When, as a practicing Optometrist I used an ophthalmoscope, I realized that the full burden of responsibility was on me, the practitioner, looking into the patient's eye. I realized that with the limited training I had in disease detection, a guess was the best I could do. A guess is just not good enough when it comes to the issue of blinding eye disease. Guesswork will just not do when the precious element of sight is involved. Therefore, it is the practitioner on the other end of the instrument that becomes more important than the instruments, drugs, or whatever is being used.

This approach to legislating the non-physician to physician status was assumed by the National Optometric Organization several years ago as a way to increase their share of the eye care market. Two years ago, the GAO instituted a study that demonstrated there were more optometrist being produced than there was market for their services: you see the reason for this type of maneuvering.

II. OPTOMETRY'S FUNCTION

Optometry provides a useful function in our society. They are exceptionally well trained in those areas in which they have historically excelled. Ophthalmology, in general, harbors no antagonism towards Optometry as long as they maintain themselves within the bounds of their training. In this regard, I might have you note that my group of Ophthalmologists in the Eye, Ear, Nose and Throat Clinic in Fairbanks employs an Optometrist who does an exceptional job on those areas for which he was employed, i.e. within the bound of optometric training and management. As an aside, I might point out that our Optometrist has had numerous problems with the State Optometric Society because of his association with us. Optometry has historically never been expected to be more than vision deficiency evaluators, that is prescribe and dispense glasses for vision problems, and evaluate eye muscle problems. As such, Optometry is properly limited by state statutes to stay out of the practice of medicine. Alaska Statute 08.72.300 (2 and 3) state "Optometry is the employment of means or methods other than the use of drugs for the diagnosis of an optical deficiency or deformity, visual or musclar anomaly of the human eye, or the prescription or application of lenses, prisms, or ocular exercises for the correction or relief of the human eye. Practicing Optometry means the diagnosis of, by means or methods other than the use of drugs, of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms, or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so." It is apparent and quite clear that the intent of this statute, as it is now in the Alaska State Statutes, is not the diagnosis of disease, not the practice of medicine, nor even the responsibility to diagnose disease, but [illegible]er to correct optical deficiencies, and visual or muscular anomalies [illegible]he prescription of lenses, prisms, or ocular exercises and to refer those patients who do not fall in this sphere.

In a landmark case decided in Alaska, the U.S. Government was found liable for $250,000 for the loss of an eye in a 4 year old child because of failure of timely referral by an Army optometrist.

From Judge James Fitzgerald's opinion:

An Optometrist should not attempt to complete a definitive diagnosis but recognize this responsbility as part of the practice of medicine. This principle is clearly stated in "The Optometric Profession".

The bill you have before you, and have had in the past, is only part of the continued effort on the part of Alaskan Optometrists to comply with their nationwide effort of organized Optometry to place itself higher on the medical ladder and hold themselves up as medically trained and qualified to diagnose and otherwise be capable of using medications in the eye.

III. OPTOMETRIC EDUCATIONAL REQUIREMENTS

A review of the Optometric educational requirements as compared with those of physician ophthalmologist document some of the comments I have made. A recent evaluation shows that Optometry has no hours in any of its training where they are under the supervision of a medical practitioner in the practice of general medicine, internal medicine, general surgery, or primary care. They have had no hours of formal education in the supervised practice of medicine and surgery of the eye. The training hours per year for Optometry is 412 and for Ophthalmology is 1677. The conclusion is that an Ophthalmologist gets more hours of training each year in his program than an Optometrist receives in his entire four year curriculum.

The truth is that after reviewing the State Division of Occupataional Licensing data, I have documented that not one Optometrist in Alaska has had any pharmacology training from any M.D. or Ph.D. in pharmacology. Not one Optometrist in Alaska has had any instruction in anything from a full time M.D. on the staff, and not one Optometrist in Alaska has had any full or part time instruction either in class or in a clinical setting by an Ophthalmologist who is a physician trained in the diagnosis and treatment of eye disease.

The bill before you is unreasonable in assuming that a hurry-up course in pharmacology can render an Optometrist capable of using drugs. Especially since the bill gives the Board of Optometry the right to determine the education and professional competence of its own practitioners. How can the members of a Board, who themselves have never had any training in the use of drugs and the diagnosis of disease, be given the power to pass on the qualifications of their own people in these medical areas.

IV. PREDISPOSITION OF ALASKA NATIVES TO NARROW ANGLE GLAUCOMA

There are approximately 35,000 native Alaskans residing in Alaska. It has been documented by the Alaska Native Health Service, as well as by independent United States and foreign researchers, that there is an extremely high incidence of narrow angle glaucoma in Alaska. Dr. Roy Box, at one of the committee hearing in 1978, said that he had dilated probably 10,000 Natives and never seen a case of near-angle glacuoma. I submit that no one in Alaska, save Milo Fritz, M.D. with his some 30 years experience could have had this type of exposure to our Native residents. I also submit that if Dr. Box did not have any case of narrow angle glaucoma with dilating 10,000 Natives, he has missed some cases of narrow angle glaucoma. Optometry says that the incidence is 1 in 18,400. The truth is in Alaska native adults the incidence is 1 in 1,900. At the Alaska Native Health Service hospital in Anchorage, there are not three operations per year or month, but three operations per week for narrow angle glaucoma. It is further documented by the Alaska Native Health Service that the incidence of this problem in Alaska natives is 18 times that of caucasians. Dilating drops cause narrow angle glaucoma attacks. Even Optometry agrees with this.

DIAGNOSTIC DROPS

This bill is commonly called a Diagnostic Drug Bill. Let me pass on to you that this is a gross misnomer. Diagnostic Drugs is a buzz word. Drugs do not diagnose. People diagnose. You have heard that this bill does not enlarge the scope of Optometric practice, but allows better and more efficient use of existing procedures, such as glaucoma testing and vision analysis in children. Dilating the eye is not a prerequsite to making a diagnosis of eye disease. The truth is that general practitioners and family practice physicians across the country as well as specialists in other fields routinely evaluate eyes for visual acuity and pathology without using any dilating drops whatever, and do a quite satisfactory job. Dilating drops are not a prerequisite for supplying children with the proper glasses correction. For years, Optometry has prided itself on non-drop methods of refraction, that is prescribing the correct glasses in children without any medications at all. One of the more common techniques is called "fogging". Anesthetic drops are not needed for the diagnosis or presumptive diagnosis of glaucoma. There are several non-contact air tonometers on the market today that are quite accurate. They are the Mackay-Mark tonometer and the American Optical air

tonometer which compare quite favorably with applanation tonometery for the measurement of introacular pressure. In addition to the illogical arguments for the use of drops is the quite important factor of competently dealing with systemic or local reactions to these medications, no matter how uncommon they may be. Optometrists have absolutely no training or preparation in the management of these potentially serious and in some cases life-threatening untoward reactions that happen occasionally with the use of these medications. How many people have to be blinded, injured, or killed before someone realizes that the camel has his head in the tent?

VI. CONCLUSION

In conclusion, I think it is grossly unfair of Optometry, through the introduction of this type of legislation to force our representatives into a position of having to pass on the medical qualifications of a non-physician group and therefore assume the responsibility for their actions. There are other arenas to decide this question more appropriately.

I would like to say that my wish is for cooperation and not competition in the health professions. Optometrists do not need to use drops to practice good Optometry. You, as legislators, are charged with guarding the public welfare for there can be no compromise in the quality of medical care to which Alaskan's are entitled. The role of the Optometrist is a vital one and can be expanded through the use of new optics technology and ideally by working as members of the eye care team. This is working in large teaching institutions, and certainly is working in our group in Fairbanks. Optometrist and Ophthalmologists should complement and support each other. A disregard for excellence that would result from enactment of the proposals in this bill will adversely affect the superior level of eye care offered to patients in Alaska. The regulation of the practice of various professional and paraprofessional groups is not for the benefit of the licensee but for the benefit of the state and its people. Nowhere does case law state that public protection will be qualified, i.e. that the risk may be increased a little bit but not a lot. The language is explicit. The intent is protection. A little bit of this bill is like a little bit of pregnancy.

210 pages - Dig

Summarized for PEN, Inc.
by Kenneth R. Safko, M.D.
1/9/78

FEB 2 19

"NEW ENGLANDERS, THEIR EYES, AND THOSE WHO PROFESS TO CARE FOR THEM"

(1)

SAMUEL E. WALLACE, Ph.D.
UNIVERSITY OF TENNESSEE Sociologist

Assisted by Robin Ostow
Brandeis University

NOVEMBER, 1974

(2)

Study sponsored by "New England Council of Optometrists," and funded by The National Institute of Health.

I. BACKGROUND

"Oculists evolved in the 19th century but did not do refractions of the eyes or prescriptions of glasses until late 19th to 20th century.* This group is now known as "Ophthalmologists." (3) "Opticians" evolved during the 19th century to "sell" glasses, primarily by trial and error from a retail supply. A splinter group began to refract and prescribe glasses in addition to selling them, and began to charge a dispensing fee. This group evolved to the present "Optometrists" and this group became recognized by licensing boards of most states by the 1920's.

II. EDUCATION OF AN OPTOMETRIST

This report deals with a single school, the "MCO" (Massachusetts College of Optometry), which evolved from a private school begun in 1896. The degree O.D. was first conferred in 1951. Today (1969-70) there are 209 students in four classes. Entrance requirements are a minimum of two years undergraduate college work with at least a "C" average. Then four years are required to earn the O.D. degree.

Wallace evaluated the quality of the students and noted the following (quotes are direct quotations from the text):

1. All students had two years of undergraduate training, with most earning a B.A. or B.S. degree.

2. The majority of students did their work at state universities or at junior or community colleges.

3. Only nine (4%) of the 209 students had an entrance grade average of B or better. Therefore, 200 students were "C" students.

4. Most of the students took pre-medical or pre-dental undergraduate courses but "had to give up their original aspirations because of their poor grades."

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*Dr. Allen notes that this is erroneous information provided to the professors. There are records of ophthalmologists prescribing glasses during the 1700's.

5. "Frustrated M.D.s make lousy optometrists."

6. The professors "complained that the students refuse to do any assigned homework, and are immature in their study habits, that they have to be spoon-fed." The students "refuse to take any initiative in the learning process" and "will learn only what is specifically presented to them in class."

Wallace, too, reviewed the faculty and noted the following:

1. Thirty full-time and fourteen part-time faculty members hold degrees varying from O.D. to Ph.D. and M.D., most (19) holding an optometric degree alone as their highest academic degree.

2. Many faculty members are related to M.D.s and "doctors and medicine always serve as positive points of reference."

3. Several teachers proudly said that some of their courses are "almost as good as the courses given in medical schools."

4. "Faculty members both share and unconsciously reinforce the anti-intellectualism and the inferiority feelings" of the students.

Regarding the quality of the courses, Wallace noted:

1. Several of the required courses "repeat knowledge that the student should already have when he arrives."

2. "Many of the courses are conducted basically on the level of a high school or freshman college introductory biology course."

3. The classes are "almost all lectures where the professors simply repeat what is in the text."

4. In a typical pathology course the practical advice given by the professor to the student if he recognizes the disease is to "refer it out."

5. "The classes are characterized by a lot of whispering, sleeping and general inattention on the part of the students."

6. The optometry students "tend, as a group, to be unimaginative and show a remarkable lack of initiative."

★ Wallace concludes that the optometric student's education "seems almost as if it is make-work to take up the four years that the optometric society has decided should be devoted to the study of optometry for the sole purpose of achieving a social status comparable to that of medicine."

III. THE CLINICAL TRAINING OF AN OPTOMETRIST

Wallace investigated the optometry student's exposure to patients and their problems. This is the non-lecture portion of their training and takes place in the optometric clinic. It is during this period of time that the student gains practical experience in both "visual examination" and hopefully some experience in the detection of pathology.

The following points of interest were made by Dr. Wallace:

1. One of the primary problems of the clinics is a "lack of patients." Students are "fortunate" to fit a dozen pairs of contact lenses "shared between two students." Students "carry out maybe 25 or 30 complete visual examinations in the course of an entire academic year."

2. The limited time an ophthalmologist spends on call in these clinics indicates "the very few cases of pathology which the optometric clinic sees."

3. "In general, 90 percent of the patients are between the ages of 15 and 30 years." (It is noted that this age group has a very low incidence of eye diseases.)

4. The optometry students provide "routine eye examinations, rather than investigating pathology, and this must be known by the general public; otherwise, at least some pathology cases would come into the clinic."

5. At another optometric clinic "cases of pathology are so few and far between at the clinic that he (the ophthalmologist) has very little to do."

6. When pathology was suspected, the workup was improper and the follow-up not documented.

7. Regarding the use of tonometry (measuring the eye pressure for purposes of detecting glaucoma), optometry students have "very little confidence in the tonometry readings." The findings with respect to readings obtained by the optometry students "seemed to be quite unstable," and interpreted by Wallace as being "worthless."

Even if we ignore the supposed exposure and training the optometry students obtain in detecting pathology, Wallace notes that in the area of visual examinations the "clinic staff did prescribe spectacles more often than was absolutely necessary."

In all fairness, Wallace believes "the patient gets an extraordinary complete and thorough refraction." (Note that he was not referring to the complete examination.)

IV. THE PRACTICING OPTOMETRIST

Because of the lower educational requirements, optometrists begin practice generally at a lower age than most other professionals. The average optometrist has been in practice 18 years and therefore has the educational standards of 1951. Wallace notes that 80 percent of practicing optometrists do not have a bachelors degree, and 33 percent do not even have an O.D. degree. Within that 33 percent group, some have had no formal training.

Wallace has obtained the following data regarding the practice of optometry in New England and contrasts it with ophthalmology as shown:

1. There is one optometrist per 8,253 population vs. one ophthalmologist per 23,545 population. There are roughly three optometrists for every ophthalmologist.

2. Optometrists are adequately distributed between rural and metropolitan regions; whereas, ophthalmologists are primarily based in metropolitan areas.

3. A patient could see an optometrist within one week 62 percent of the time; and, in one-fourth of these optometrists, the patient could be seen the same day.

   In contrast, a non-emergency eye patient could not be seen for at least two weeks and on the average must wait three months or more for an appointment with an ophthalmologist.

4. Over one-half of the optometrists work outside of their office practice; whereas, the great majority of ophthalmologists work full-time at their office and related hospital practice.

5. The majority of optometrists take 2 - 3 weeks off per year while the majority of ophthalmologists take off one month per year.

Wallace studied the factors relating to office efficiency of eye practitioners and noted the following:

1. Optometrists schedule 30 - 60 minutes for an examination with an average of 40 minutes. Ophthalmologists allow an average of 20 minutes for a complete eye examination.

2. One-fourth of the optometrists have no office help while another one-half have one office person.

   Every ophthalmologist has at least one office person while 37 percent have two or more.

3. Seventy-one percent of optometrists could increase their patient load with no increase in space or office help needed. The average possible increase was ten patients per week, with 12 percent optometrists indicating they could see 16 or more additional patients per week.

   In contrast, 87 percent of the ophthalmologists could not increase their patient load. Wallace summarized that "Ophthalmologists work nearly twice as quickly as optometrists, are in their office 10 - 15 more hours per week, are fully booked 11 weeks further in advance and see almost twice as many patients every week."

Wallace observed the efficiency and competency of an ophthalmic assistant who had had only two years of training and contrasted him with a recent graduate of MCO. He noted that only "a few minutes of observation was needed to conclude that the ophthalmic assistant was far superior in all respects."

Wallace reported the opinion of a practicing optometrist, "although optometry is a clean job, it doesn't have much dirty work or tension, I would say that seventy percent of the work is mere technician work. Anyone could do it with some training."

V. OPTOMETRY LOOKS AT OPTOMETRY

The use of drugs (cycloplegics) by optometrists is an "explosive" question for optometrists. Wallace reported "a cycloplegic refraction is in 95-99 percent of the cases not valuable." He noted that under some state laws "optometrists are not forbidden the use of drugs, and thus some of them have decided to go ahead and use drugs when necessary."

Wallace speculated that "the use of drugs in optometric practice is something of a status issue among optometrists."

Optometrists considered the quality of current optometric graduates and concluded that the students "were not given sufficient clinical experience."

VI. SUMMARIZING NOW AND THE FUTURE

Wallace concluded that based on time and effort spent by optometrists it appeared that "optometrists perform higher quality refractions than do ophthalmologists." However, in terms of pathology detection, he judged from one-fifth to one-half of optometrists to be incompetent.

In terms of quality care alone, ophthalmologists "without exception delivered high quality care."

Wallace states that "for the person with healthy eyes, you're better off seeing an optometrist."

Recognizing the "incompetent optometrists found among recent graduates as well as among older ones," and observing the "law and inadequate academic standards at the MCO," coupled with the "poor quality of optometric performance in pathology detection," Wallace suggests "the average level of patient care in the future will deteriorate."

Wallace notes that organized optometry is attempting to establish 10 - 20 new colleges of optometry, and that "at a time when we need more ophthalmologists, we are getting more and more optometrists." The current over-supply of optometrists increases "commercial competition," gives "them so little to do that they do even less" contributes to lowering "the income of all practitioners and gives them no choice but to sell spectacles in order to survive."

"Quality is optometry's most pressing need, not quality." Recognizing the quality of optometry students, Wallace reports that half of the current students "probably should be dismissed before they have a chance to go into practice."

Wallace suggests that increased communication between ophthalmologists and optometrists would indicate to many optometrists "just how inadequate their examinations now are."

Alluding to the optometric-ophthalmologic conflict, Wallace notes that "optometrists have numbers on their side while ophthalmologists have everything else." "Ophthalmologists should begin now to assert the changes which they too know should be made in optometry."

In summary, Wallace states that with the present under-utilization of optometrists "at least 10,000 vacancies now exist every week in optometrists' appointment schedules," and that no new optometrists are needed in New England for at least three years.

In contrast, there is a serious shortage of ophthalmologists and projected growth of ophthalmological manpower falls far below that required to just maintain the present level of "over-utilization."

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How the General Practitioner Can Determine The Need for Ophthalmologic Referral

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

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

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

Method

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

Address correspondence to Dr. Campell at PO Drawer 3151, Martinsville VA 24112.

Submitted 1-12-79.

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

Results

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusions

How, then, can the non-ophthalmolgic practitioner know when a patient should be referred to an ophthalmologist? Most often, the study shows, through the basic medical triad of history, visual acuity, and looking at the external eye with a flashlight. Family physicians can take heart at this. And they may be cheered as well to know that the success of this triad obviates the need for sophisticated instruments. In only 23 of the 716 patients suspected of having disease was an instrument required that is not in the office of most physicians, namely, a slit lamp.

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

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

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

Acknowledgment

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

FEB 2 19

A SURVEY

of the
EXPERIENCES IN THE USE OF
OPHTHALMIC PHARMACEUTICAL AGENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Question 6. In conjunction with question #5, can you supply what pharmaceutical agents (mydriatics,cycloplegics, miotics and anesthetics either generic or brand name) have induced these side effects in some of your patients?
Please estimate by number or if able specify how many reactions have been induced by the said pharmaceutical agents in your practice for the year 1978.

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

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

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

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

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

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

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

SUMMARY and CRITIQUE

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

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

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

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

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

FEB 2

Preliminary Agreement between the Alaskan Association of Optometry represented by Roy Box, O.D. and James N. Matson, O.D. with the Alaska Association of Ophthalmology represented by Peter Canavan, M.D., Samuel A. McConkey, M.D., Robert Page, M.D., Ron Tokar, M.D.

Others attending the meeting were: Rick Urion, lobbyist for the State Optometric Association; Jeff Landry, lobbyist for the Alaska State Medical Association.

RE: House Bill 79 and Senate Bill 75 - concerning the use of medications in the eye by Optometry

It is agreed by both parties that if a solution in this endeavor is to be reached that a compromise position has to be made. That compromise is as follows:

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 [redacted] 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. Optometrists will take a written exam on the above given by a special test committee comprised of two Optometrists and two Ophthalmologists chosen by each respective professional organization to prove competence in the above subjects. The point of a clinical proficiency demonstration is unsettled by both parties at this time. Any course taken by an Optometrist desiring to use medications in the eye for diagnostic purposes will have to be approved by a committee of two Optometrists and two Ophthalmologists chosen by each respective professional organization.

5. In the current State Statutes regarding Optometry, the word "diagnosis" wherever it appears will be changed to "detection".

6. Mandatory referral guidelines will be followed by all Optometrists. Referral guidelines will be clearly delineated in the Bill and adhered to by all Optometrists whether or not they wish to use drugs in the exam. Those referral guidelines are as follows:

   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.

1. Abnormality of Vision:

A. Failure on the part of an individual to obtain 20/30 vision in each eye, 20/30 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 redness, 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 previous 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.

3. Abnormalities of Motor Function:

A. Strabismus. A deviation of the eyes from their normal parallel position in straight ahead gaze or gaze in any direction. *This needs to be further defined and refined for Optometry to accept. [redacted].
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.

In recent years, the public as well as legislators have been hesitant to take the word of the medical profession as gospel. While this skeptical attitude is often a healthy one, it must be remembered that PHYSICIANS ARE STILL THE LEGAL EXPERTS ON MEDICAL ISSUES. On the issue of optometry drug laws, the medical profession has the great preponderance of evidence in its favor and legislators would be wise to follow its advice.

Kay S. Kelly

Loyola Law Review

Volume 24, 1978

Oregon Optometric College Professor Says Student Apathy Prompted Resignation

Dr. J. Gordon Betts, a practicing ophthalmologist in Portland, Oregon, and a recent former part-time faculty member at Pacific University College of Optometry, resigned his faculty post as Assistant Professor of Pathology because of a "lack of student interest."

This is the same College of Optometry that produced John Shank, O.D., who initially examined and failed to promptly refer Timothy Steele, the eight-year-old military dependent whose eye was removed because appropriate treatment was not instituted in time.

In this highly publicized case, United States District Judge James M. Fitzgerald called the optometrist's failure to inform or refer a "violation of the governing principles of professional standards," and concluded that Timothy Steele was entitled to recover from the United States for the loss of his right eye.

The College of Optometry is presided over by Willard Bleything, O.D., who was an "expert" witness for the defense. He showed an identical ignorance of signs of disease in the eye as defendant optometrist Shank. All the medical doctors who testified in the trial, including a defense witness, faulted his medical knowledge.

Dean Bleything testified, "A significant part of optometric training is given over to recognition of disease of the eye." During the time of Shank's schooling, Dr. Betts was the only qualified instructor who was teaching disease recognition.

Dr. Betts' reason for resigning from Pacific University College of Optometry was brought out in testimony he gave to the Committee on State and Federal Affairs of the Oregon House of Representatives on March 24, 1975. On that occasion he was testifying in what turned out to be a futile effort to defeat an optometric drug law in that state.

In the light of the Timothy Steele case and Dr. Bleything's testimony, Dr. Betts' testimony takes on new significance. He told the Oregon House Committee that, "My salary was satisfactory and the equipment was up to date. The only problem was student interest and participation. Eighty to ninety percent of the time the student was not in attendance with his patient and consequently never benefited from the experience or followup.

"This leads me to believe," Dr. Betts reported, "that the desire and/or ability of the recent graduates from this College to detect eye diseases is very superficial. It would seem they are not interested in this aspect of ocular problems and have little or no background in ocular diseases and how they relate to general body health. Their best training is in what they are presently licensed to do (measure for and fit eyeglasses)."

He continued, "The post-graduate education of the use of dangerous drugs does not open the doors to accurate ocular diagnosis. One must be aware of the abnormal before one can recognize its presence."

Many optometrists do not believe their profession should attempt to perform medical functions.

Loren L. Pace, O.D., of Findlay, Ohio, in a letter to the editor of the Journal of the American Optometric Association, Vol. 49 - No. 5 - 1978, wrote, "For the past several years the major theme and emphasis of official optometry in every available medium of communication has been 'primary health care provider.' In particular the younger O.D.s are evincing a marked interest in moving the profession toward a rudimentary form of quasi-medical practice, leading to a potentially harmful and dangerous schism."

Despite the warning of ophthalmologist J. Gordon Betts, the expressed reservations of optometrist Loren L. Pace, and the loss of a youngster's eye whose root cause can be traced to the optometric concept of "primary care" (seeing an eye patient before an M.D. does), organized optometry continues its efforts to "sell" the "primary care" concept and lobby for drug laws across the nation. Although their efforts were thwarted in 15 of 17 states last year, bills have already been introduced in 10 states this year. ●

West Virginia Optometric Drug Law Causes Governor Concern

Governor John D. Rockefeller IV of West Virginia, in a letter to Richard C. Bashid, M.D., chairman of the West Virginia Committee to seek repeal of that state's optometric drug law, has expressed concern about the law and assured the Charleston ophthalmologist that he will "keep an open mind" regarding the issue.

A bill has been filed that would repeal the odious 1976 drug law now permitting optometrists, without medical training, to use dangerous drugs for therapeutic purposes. The bill is sponsored by Troy Wayne Hendricks of Madison and Charlotte Lane of Charleston, West Virginia.

In his letter to Dr. Bashid, Governor Rockefeller states, "Thanks for your letter and information about proposed changes to the Optometric Drug Bill of 1976.

"I will be following this legislation closely, and am keeping an open mind to arrive at the facts. I am concerned about the scope of drugs which optometrists can dispense and the amount of training which they are given in the field of pharmacology." ●

FEDERAL JUDGE RULES AGAINST U.S.

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

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

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

Judge Fitzgerald's decision was rendered on October 20, 1978, in the case of Timothy R. Steele and Robert K. Steele, plaintiffs, vs. The United States of America, defendant. In his opinion, Judge Fitzgerald stated, "An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases, he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to seek a qualified medical doctor."

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

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

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

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

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

On June 10, 1974, Timothy was again examined by Dr. Shank and it was then that he discovered that the vision in Timothy's right eye was limited to light perception. At this point, Dr. Shank made to Letterman Army Medical Center where he was examined on July 12, 1974.

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

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

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

A SAD SUMMARY:

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

WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsi-

WHY "THE PEN?"

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

then used drops to dilate the pupil and looked inside the eye. He diagnosed Timothy's eye condition as accommodative esotropia, which is correctable by eyeglasses. He wrote a prescription for eyeglasses and made an appointment for Timothy to return to the clinic on January 29, 1974, for a checkup.

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

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

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

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

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

THIS CHRISTMAS:

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

Memory copies Item 6

Dr. Jeffrey A. Gonnason
Doctor of Optometry
Medical - Dental Bldg.
140 East 5th
Anchorage, Alaska 99501
— — —
Telephone (907) 276-2080

February 20, 1981

Senator Charles H. Parr
Senate HESS Committee
Pouch V
Juneau, Alaska 99811

Dear Sen. Parr:

Please convey to your committee my strong support for Senate Bill #136, allowing optometrists to use those drugs and drug related procedures for which they are trained.

It is more than a little disconcerting to be recently trained in Oregon to use drugs, but not be able to use them in Alaska. It is hard to see how the patient does not come out the loser from this restriction in the range and quality of services I am qualified to perform. Furthermore, Alaska will not be able to attract a high calibre of practitioner in the future if this policy continues for long.

Please allow the Board of Examiners in Optometry to function like other health care boards in determining the appropriate activities of the professionals it oversees.

Respectfully yours,

Jeff A. Gonnason

Jeffrey A. Gonnason, O.D.

JAG:rms

Eagle River Optometric Center
Jeffrey G. Keene, O.D.
Eagle River, Alaska (907) 694-2581
Member
American Optometric Association

February 19, 1981

Senator Tim Kelly and
Senate HESS Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Gentlemen:

I know that you've been bombarded by both sides concerning drug use by doctors of optometry. I have talked to many of my Eagle River-Chugiak patients in regard to this legislation. They cannot understand that if these ophthalmic drugs are a potential help to them, why the law wasn't passed many years ago.

Since I am the only vision care doctor in this area, I am the primary entry point into the health care system for many people. I don't want to practice general medicine --- I do want to help my patients within the scope of my education, with minor eye infections, and I do want to recognize an eye health problem or a general health problem that is visible with the help of ophthalmic drugs, so I can refer the patient to the proper health care practitioner.

Ophthalmic drug use by doctors of optometry has an overwhelming benefit-to-risk ratio, as evidenced that all three military services, the Veterans Administration hospital system, and thirty two states allow their use. I have administered ophthalmic drugs extensively while serving in the Navy, using them for minor eye infections and contact lens overwear reactions, and for detecting eye tumors, diabetes, hypertension, retinal tears, vascular disruptions, brain tumors and other health problems. Also I might add that in my travels to Bush communities in Alaska, I have been asked to evaluate various eye infections and disorders and help in planning the best therapy. Since our training in this area is about one hundred times more in depth than any community health aide, this only makes sense.

I have taken several pharmacology and physiology courses that deal with ophthalmic drugs and I am licensed to use them in Oregon. Optometrists aren't going to lose if this legislation doesn't pass; it will be my patients and your constituents who will be the losers.

Sincerely,

Jeffrey G. Keene, O.D.

Jeffrey G. Keene, O.D.

JGK/ml

cc: Other members of HESS Committee
Sen. Brad Bradley

WITNESSES FOR
SENATE H.E.S.S. MEETINGS

SB 136
2-27-81

Name	Address/Phone	Representing
Maynard Falconer	1345-W-9th 272-2557	Alaska Optometric Assoc
Phillip W. Baer, O.D.	3401 Denali Anch. 99503 276-2120	Board of Examiners in Optometry
Jim MATSON, OD	8006 Laurel Ave Juneau, AK	Alaska Opt. Assoc
Margie Alland, Regulation Spec. Dick Long, Investigator	Dept. of Commerce for Harry Treager	Occupational Licensing
DAVID E. JOHNSON M.D.	3612 TONGASS KETCHIKAN	ALASKA STATE MEDICAL ASSOCIATION

Ophthalmologists

Anchorage:	Donald Dippe
	Marvin Grendahl
	Thomas Harrison
	Jan Nyboer
	James Patterson
	Kenneth Richardson
	Robert Rigg
	Joseph Shelton
	Jon Shiesl
	Mahlon Shoff
	Boyd Skille
Anchor Point:	Milo Fritz
Fairbanks:	John Esters
	William Kinn
	Sam McConkey
	Bruce Wolf
Ketchikan:	Ron Tokar
Soldotna:	Peter Cannava

Optometrists

Anchorage:	Aharon Sternberg
	Phillip Bach
	Robert Miller
	Maynard Falconer
	James Falconer
	Dennis Albert
	George Hall
	Boyd Walker
	Thomas Roselius
	Thomas Harbour
	Jeffery Allen Gonnason
	William Faulkner
Fairbanks:	Nancy Lefevre
	Curtis Johnson
	Robert Hammond
Ketchikan:	E.E. Smith
	E.L. Craig
	Ricky Dean Swearingen
Kenai:	Robert O'Connel
	Dennis Swarner
K diak:	John Shank
North Pole:	John Charles Cobbett
Palmer:	James Taylor
Sitka:	Timothy McLaughlin

(compiled by Rocky)
(2-27-81

DISTRIBUTION OF OPTOMETRISTS AND OPHTHALMOLOGISTS IN ALASKA
source: Alaska Division of Occupational Licensing and the Alaska State Medical Association

Location	Optometrists	Ophthalmologists
Anchorage	12	11
Fairbanks	3	4
Juneau	2	1
Kenai-Soldotna	2	1
Ketchikan	3	1
Kodiak	1	0
North Pole	1	0
Palmer	1	0
Sitka	1	0
Anchor Point (Homer)	0	1
TOTAL	26	19

note: Licensure is not required for those practicing with the armed services or with the United States Public Health Service (AS 8.64.370), so those persons are not reflected on this list.

Final

Official Business

Alaska State Legislature

Senate

Committee on

Health, Education & Social Services

Charlie Parr, Chairman
Terry Stimson, Vice-Chairman
Vic Fischer
Tim Kelly
Mike Colletta

Pouch V
State Capitol
Juneau, Alaska 99811

465-4907
465-4908

Committee Substitute for Senate Bill 136 - Optometry (HESS)

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

The Department of Health and Social Services shall establish specific diagnostic drugs and the strengths thereof within the limits of AS 08.72.300(7) by regulation.

(see page 3)

* Section ? 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.

(The intent of this section is for writing or advertising, not orally.)
(If appropriate, please include language to specify the intent.)

* Sec. : 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~~ health care practitioner for further evaluation.

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

(2) "optometry" is the examination, other than by the use of drugs, except diagnostic drugs as defined in this section, 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 AS 08.72.300(3) is amended to read:

(3) "practicing optometry" is an examination, other than by the use of drugs, except diagnostic drugs as defined in this section, 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 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 a supplement to either of them.

* Section 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.

Please include the following intent in the above section:

The board of optometry must approve those optometrists who qualify to use diagnostic drugs and shall issue an endorsement in addition to regular certification.

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

(b) (Notwithstanding necessary? (a) of this section,) an ophthalmic drug identified by regulation of the ~~Board of Examiners in Optometry~~ Department of Health and Social Services 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.~~ 08.72.305 (see page 3)

* Sec. 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 ophthalmic drug identified by regulation of the ~~Board of Examiners in Optometry~~ Department of Health and Social Services to an optometrist who is authorized to use the drug as provided in AS 08.72.~~277~~. AS 17.15.010 and 17.15.020 do not apply to the sale of an ophthalmic drug identified by regulation of the ~~Board of Examiners in Optometry~~ Department of Health and Social Services by one optometrist authorized to use the ophthalmic drug to another optometrist authorized to use the drug.

ALASKA STATE MEDICAL ASSOCIATION
4107 Laurel Street, Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891

SB 136 file

March 7, 1981

The Honorable Charles Parr
Chairman
Senate HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I am writing to follow up on my previous testimony to your committee, both in person and by teleconference, regarding SB 136. I would also like to make reference to the preliminary compromise between the optometrists and the medical doctors that was worked out last year, and to address the suggested language to amend SB 136 authored by the DHSS.

Diagnostic pharmaceutical agents that could, with proper safeguards, be considered reasonably safe for use by optometrists include a pure mydriatic, such as phenyloephrine hydrochloride 2.5% or 5%; combination cyclopelgics and mydriatics, to include tropicamide 1% and cyclopentolate hydrochloride 1%; and a topical anesthetic such as proparacaine 0.5%. This list of drugs would satisfy the economic wishes of those optometrists who wish to expand their practices without unduly endangering the Alaskan public.

The Alaska State Medical Association is strongly opposed to optometrists using therapeutic agents. Medications are expensive when prescribed needlessly, dangerous when prescribed inappropriately, and well outside the scope of training for most optometrists currently practicing in the state. The DHSS amendments included this limitation.

We believe it is very important that the public be given the opportunity to make an informed decision regarding their vision care when an abnormality is detected. We believe it is essential that the patient understand that they are seeing a non-physician in cases where a pathologic condition is suspected. The DHSS amendments assured this.

Since it is the optometrists who are seeking expansion of their definition of their profession, not a limitation on existing practice by the medical profession, we believe it very important that the Legislature protect the public interest. The consistent testimony by members of the public at the recent teleconference was solidly in support of the Legislature moving very slowly, if at all, regarding expansion of the definition of optometry.

We are prepared to provide further information and recommendations regarding this legislation, should you wish to have further information from us.

Thank you for the opportunity to offer testimony on this most important matter.

Yours truly,

David E. Johnson, M.D.
President

cc Rep. Don Clocksin, House HESS

Alaska State Legislature

TELECONFERENCE HEARINGS

DATE: 3-9-81

LOCATION: Ketchikan Info Office

SUBJECT: SB 136, S. H.E.S.S. Practice of Optometry

NAME	REPRESENTING	ADDRESS	PHONE	HERE TO OBSERVE	HERE TO TESTIFY
Rick Swearingen, OD	Ketchikan Vision Clinic	P.O. Box 7131	225-2020	X	
David E Johnson MD	Alaska State Medical Assoc.	3612 Tongass Ave. Ketchikan	225-5149		X
Ron Tekar MD	ophthalmology	POB 8436 Ketchikan	225 3320	X	
Oliver W. Hauger	Self	3420 Baranof Ketchikan	225-3293		X
John J. Chesarek R.Ph	Self	Box 5745 Ketchikan	[illegible]	X	

TLF

Alaska State Legislature

TELECONFERENCE HEARINGS

DATE: 3/9/81
LOCATION: Soldotna
SUBJECT: SB. 136
S./H.E.S.S. Committee

NAME	REPRESENTING	ADDRESS	PHONE	HERE TO OBSERVE	HERE TO TESTIFY
Robert O'Connell	Optometry	Box 4187 Kenai	395-7575		X
Peter Elamaitis	opthalmology	Box 1625 Soldotna	2-1462		X

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CS for Senate Bill No. 136 (HESS)
Title "An Act relating to the practice of optometry and authorizing the use of ophthalmic drugs by optometrists."
Requested by Commissioner's Office Date 4/7/81

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Public Health/Division of Public Health
BRU, Program, or Subprogram(s) Affected Family Health Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	1.5	0	0	0	0
300 CONTRACTUAL	0	19.2	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL		20.7				

FUNDING (Thousands of Dollars)

GENERAL FUND	0	20.7	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

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

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

line 300 - The Department of Law advised us to use a sum of $80/hr. for a contract attorney.

$80/hr. x 40 hr./wk. x 6 wk. = $19,200.

The funding is to provide for contracting with a private attorney to draft the proposed regulation. As part of the process, the contract attorney will work in con unction with designated representatives from the fields of optometry and opthamology. We will fund the travel and per diem at state rates for the individuals to come to Juneau. After the proposed regulations are drafted, they will be handled as per the "Drafting Manual for Administrative Regulations" with public hearings to be held at key locations around the state.

IV. DATE 4/7/81 PREPARED BY David Bruce
AGENCY Department of Health and Social Services
PHONE 465-3090

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named) M&B Approval [signature] Date 4/9/81

33-001 (Rev. 12/80

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CS for Senate Bill No. 136 (HESS)
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Requested by Commissioner's Office Date 4/7/81

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Program Category Affected Public Health/Division of Public Health
BRU, Program, or Subprogram(s) Affected Family Health Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis sec

EXPENDITURES (Thousands of)

		FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100	PERSONAL SERVICES	0	0	0	0	0	0
200	TRAVEL	0	1.5	0	0	0	0
300	CONTRACTUAL	0	19.2	0	0	0	0
400	COMMODITIES	0	0	0	0	0	0
500	EQUIPMENT	0	0	0	0	0	0
600	LAND & STRUCTURES	0	0	0	0	0	0
700	GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
	TOTAL		20.7				

FUNDING (Thousands of Dollars)

GENERAL FUND	0	20.7	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

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

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IV. DATE 4/7/81 PREPARED BY David Bruce
AGENCY Department of Health and Social Services
PHONE 465-3090

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/80

USE OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS
BY STATE, TYPE, AND CLASSIFICATION

State	Optometric Drugs		Classifications of Drugs Used					
	Diagnostic Only	Diagnostic & Therapeutic	Cycloplegics	Mydiatrics	Topical Anesthetics	Dyes such as Fluorescein	Miotics	None Specifically Listed In Statute or Regulations
Arizona	X		X	X	X			
Arkansas	X		X	X	X	X		
California	X		X	X	X			
Delaware	X		X	X	X		X	
Florida	X	X						X
Georgia	X							X
Idaho	X							X
Indiana	X							X
Iowa	X		X	X	X			
Kansas	X		X	X	X			
Kentucky	X		X	X	X		X[E]	
Louisiana	X							X
Maine	X			X	X			
Minnesota	X							X
Montana	X		X	X	X	X	X[E]	
Nebraska	X		X	X	X			
Nevada	X		Y	X	X		X	
New Jersey	X							X
New Mexico	X							Y
North Carolina	X	X						X
North Dakota	X							X
Oregon	X		X	X	X	X	X[E]	
Pennsylvania	X		X	X	X		X	
Rhode Island	X			X	X		X	
South Dakota	X							X
Tennessee	X		X	X	X		X	
Utah	X		X	X	X			
West Virginia	X[x]	X[x]						X
Wisconsin	X		X	X	X	X	X[E]	
Wyoming	X		X	X	X	X	X[E]	
TOTAL	30	3	16	18	18	5	10	12

Key
E = In Emergency Use Only x = Excludes Oral or Injectible Drugs Source: American Optometric Association (1980)

465-3030

August 6, 1981

The Honorable Richard Eliason
Alaska State Senate
P. O. Box 143
Sitka, Alaska 99835

Dear Senator Eliason:

Recently you requested that the Department review two versions of Senate Bill 136, regarding the use of certain ophthalmic drugs by optometrists. We have conducted that review and our summary notes are attached for your reference. We also included in our review a third version, the draft of SB 136 which we provided to you and was the basis of the Senate Finance Committee Substitute prepared by Legislative Affairs Agency, Legal Division.

First, although the legal attorney made substantial revisions to the draft we provided to your office, we can support the final product produced. The draft finance version is a superior bill to CSSB 136(HESS) in the following ways:

A. It involves the State Medical Board in the establishment of educational and examination requirements, with a six month time limit from which to hold public hearings from the time of the effective date.

B. It mandates that both classroom and clinical educational experience is required to use ophtnalmic drugs in practices.

C. It mandates that the educational and examination requirements address reactions to pharmaceutical agents and treatment of adverse reactions.

D. It mandates that the optometrists must take an examination in use of ophthalmic drugs, while CSSB 136(HESS) does not.

E. It puts the authority for selecting and regulating drug use with the Board of Examiners in Optometry and the State Medical Board, rather than in the Department of Health and Social Services as CSSB 136(HESS) does. We have neither the staff expertise to evaluate the use nor the regulatory power to control possible optometrist misuse. We believe CSSB 136(Finance) to be a superior bill in this respect.

F. It requires statutorily that the optometrist must publicly display his or her certificate in a conspicious place. We believe this is important to protect the consumer since there will be two classes of optometrists practicing in the state - one authorized to use drugs and one not. We believe this provision is a good one and in the public's best interest.

In conclusion, the Department of Health and Social Services has no objection to the passage of CSSB 136(Finance) as drafted by Legislative Affairs Agency, Legal Division for it protects the public health by limiting use of ophthalmic drugs to only diagnostic ones, mandating clinical as well as classroom training in use of drugs, requiring continuing education to keep skills current, and provide certain consumer protection provisions to make the public more aware in the purchase of eye care services.

We anticipate no fiscal impact to our Department if CSSB 136(Finance) were passed into law.

We appreciated the opportunity to work with you on this matter.

Sincerely,

Helen D. Beirne
Commissioner

Enclosures

COMPARISON OF THREE APPROACHES TO AUTHORIZE OPTOMETRISTS TO USE CERTAIN OPHTHALMIC DRUGS IN THEIR PRACTICES (SB 136)

neral Topic Regarding Use Ophthalmic Drugs	Senate HESS Version (CSSB 136) (HESS)	Senate Finance Drafted Version CSSB 136 (Finance) (Prepared by Department of Health and Social Services)	Senate Finance Drafted Version CSSB 136 (Finance) (Prepared by Legislative Affair Legal Division)
Educational Requirements a) Who prescribes? b) Requirement for clinical and classroom training? c) Continuing Education? d) Specific topics to be covered in course work noted in Statute? e) Are educational institutions required to be accredited?	a) Board of Examiners in Optometry only. b) No Statutory mandate for clinical training. Board of Examiners in Optometry determines. c) Yes; Board of Examiners in Optometry only prescribes. d) None; Board of Examiners in Optometry determines. e) No reference; Optometry Board prescribes. (Refer: Pg. 1, line 9-12, AS 08.72.050(6))	a) Board of Examiners in Optometry with advice and consent of the State Medical Board, with such consent to be provided within six months from effective date. b) Yes; both general and clinical educational requirements statutory mandated. c) Yes; Board of Examiners in Optometry with advice and consent of the State Medical Board with such consent to be provided within six months of effective date. d) Yes; emphasis required on systematic effects of and reactions to pharmaceutical agents, including the treatment of any adverse reactions that may occur. e) Yes; and both Board of Examiners in Optometry and State Medical Board must approve. (Refer: Pg. 1, AS 08.72.050(6))	a) Board of Examiners in Optometry and State Medical Board shall jointly adopt. Public hearings shall be held on regulations within six months of the effective date. b) Yes; both general and clinical educational requirements statutorily mandated. c) Yes; Board of Examiners in Optometry and State Medical Board shall jointly adopt. Public hearings shall be held on regulations within six months of the effective date. d) Yes; emphasis is on systemic effects of and reactions to pharmaceutical agents and the treatment of adverse reactions to pharmaceutical agents. e) Yes; and both Board of Examiners in Optometry and State Medical Board must approve. (Refer: Pg. 1, Line 9-22, AS 08.72.061; Pg. 4, Line 4-7,

eral Topic Regarding Use Ophthalmic Drugs	Senate HESS Version (CSSB 136) (HESS)	Senate Finance Drafted Version CSSB 136 (Finance) (Prepared by Department of Health and Social Services)	Senate Finance Drafteu Version CSSB 136 (Finance) (Prepared by Legislative Affair: Legal Division)
Specific Examination Requirements for Drugs a) In Statute? b) Who prescribes? c) Specific topics to be covered?	a) None b) None c) None	a) Yes b) Board of Examiners in Optometry with advice and consent of the State Medical Board with such consent to be provided within six months from the effective date of of this Section. c) Systematic effects of and reactions to pharmaceutical agents, including the treatment or adverse reactions that may occur. (Refer: Pg 1, AS 08.72.050(6))	a) Yes b) Board of Examiners in Optometry and State Medical Board shall jointly adopt. Public hearings to be held within six months. c) Systematic effects of and reactions to pharmaceutical agents and treatment of adverse reactions to pharmaceutical agents. (Refer: Pg. 1, line 9-22 and pg. 4, line 4-7)
Types of Ophthalmic Drugs Permitted a) Diagnostic and/or therapeutic b) Who specifies generic types?	a) Diagnostic b) Department of Health & Social Services. (Refer: Pg. 1, AS 08.72.061)	a) Topical ocular diagnostic drugs. b) Board of Examiners in Optometry with advice and consent of the State Medical Board, with such consent to be provided within six months of the effective date of this section. (Refer. Pg. 2, AS 08.72.050(7))	a) Diagnostic drugs. b) Board of Examiners in Optometry and the State Medical Board shall jointly adopt regulations. Public hearings shall be held within six months after effective date. (Refer: Pg. 1, line 23-26))

eral Topic Regarding Use Ophthalmic Drugs	Senate HESS Version (CSSB 136) (HESS)	Senate Finance Drafted Version CSSB 136 (Finance) (Prepared by Department of Health and Social Services)	Senate Finance Drafted Version CSSB 136 (Finance) (Prepared by Legislative Affairs Legal Division)
Consumer Protection a) Endorsement on certificate to distinquish those Optometrists qualified to use drugs in practice? b) Limiting use of professional title? c) Statutory mandate for display of certificate?	a) Yes) Yes c) No (Refer: Pg. 1, line 14-29 and Pg. 2, lines 1-2, AS 08.72.061 & AS 08.72.264)	a) Yes b) Yes c) Yes (Refer: Pg. 2 & 3, AS 08.72.061, AS 08.72.264, AS 08.72.286)	a) Yes b) Yes c) Yes (Refer: Pg. 2, line 5-22, AS 08.72.264-286)
Referral to Other Medical Specialists a) Mandatory when possible existense or pathological conditions.	a) Yes (Refer: Pg. 2, line 3-9, AS 08.72.286)	a) Yes (Refer: Pg. 3, AS 08.72.286)	a) Yes
Effective Date	None	Immediate	Immediate

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

Center for Continuing and
Post Graduate Education

Pennsylvania College of Optometry

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

INTRODUCTION

OCULAR THERAPY FOR THE OPTOMETRIC PRACTITIONER #750

The following material will define and describe the 150 hour offering of Ocular Therapy for the Optometric Practitioner #750. The introductory remarks present some basic elements regarding the structure of the program.

1. The program is given at a singular site or multiple sites based on suggestion and considerations of the State organization. Each site is limited to a maximum of approximately 60 doctors.

2. A total of approximately 20 lecturers participate in presenting 96 hours of lecture. The faculty all hold professional degrees including O.D., M.D., Ph.D., etc. All are experienced clinicians and academicians from various departments of medical and health care institutions and are well indoctrinated in the goals and needs of optometrists.

3. Given sufficient notice (about 2 months), the course(s) could begin whenever specified.

4. A suggested schedule is 2 days of lecture followed by a 2 to 4 week break. The normally preferred days are a Saturday and Sunday combination with adjustments made for holidays, professional meetings, etc. However, there is flexibility in the program to create virtually any type schedule necessary to meet the requirements of the doctors in specific states.

5. Two examinations are normally administered:

   a. Three hour examination covering material in first half of course (Examination, Part I).

   b. A three-hour final examination covering material in second half of course (Examination, Part II)

6. Examinations are presented in a sufficient number of rooms to assure adequate spacing between the doctors taking the examination.

7. Examination, Part I consists of approximately 200 questions of the multiple choice variety and Examination, Part II consists of approximately 200 questions of the same type.

8. Forty-eight hours of clinic are held at a suitable location within the state. Facilities of the Pennsylvania College of Optometry are available, and clinic sessions could be held in The Eye Institute which would represent a savings to the State Association of travel and lodging of the clinical staff.

9. Doctors must demonstrate confidence in each of 6 specified areas for completion of the clinic session (see description).

10. Student numbers are of particular importance in the clinic. Every attempt is made to maintain a ratio of 6 doctors per 1 staff member.

11. Special tutorials and course reviews (delivered on Friday evenings prior to lecture week-ends) are available as part of the pre-requisites for eligibility. Tuition for these tutorials and reviews are not included in the total program tuition. Rate for 3 hour session shall be $25.00 per person with minimum group size of 5 and maximum size of 10.

12. The program is costed on the basis of direct and indirect expenses plus a 15% institutional fee. Any additional services beyond the program structure and content, (i.e. testimony, consultation, etc.) are charged separately to the State Association.

13. The recommended printed materials for the courses include the following:

    a. The Pharmacological Basis of Therapeutics, by L. S. Goodman and A. Gilman (a recognized pharmacology reference text) priced at approximately $50.00 per book.

    b. Manual of Ocular Therapy, by Deborah Pavan Langston, priced at approximately $15.00 per book

    c. Complete preprinted, bound and indexed lecture outline notes priced at approximately $40.00 per book.

    d. Each student is supplied with a comprehensive bibliography from which he/she may select additional reading material.

14. Additional considerations include the following:

    a. A minimum passing grade of 70 is recommended with each Examination (Part I and Part II) counting equally in the final grade.

    b. The doctor may be permitted 4 days of absence from lectures but no absence from the clinic. Notwithstanding such absences, the doctor remains responsible for all material covered in all sessions.

    c. Forms are supplied by the Pennsylvania College of Optometry for strict monitoring of attendance records.

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Philadelphia, Pa. 19141
215 424 5900

Center for Continuing and
Post Graduate Education

Pennsylvania College of Optometry

The Eye Institute
1201 West Spencer Street
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215 276 6000

COURSE TITLE: OCULAR THERAPY FOR THE OPTOMETRIC PRACTITIONER

COURSE NUMBER: 750

DESCRIPTION: An in depth post-graduate curriculum including 150 hours of didactic (102 hours) and clinical (48 hours) education in the diagnosis, treatment and management of ocular diseases. Emphasis is placed upon pharmacology and ocular therapeutics; diagnosis and management of anterior segment disease and glaucoma; and recognition of ocular manifestations of systemic disease.

COURSE OBJECTIVES:

1. To improve the practicing optometrist's knowledge base and clinical skills in the following areas:
   a. Knowledge of the presentation, examination, differential diagnosis, treatment and management of ocular disease.
   b. Clinical experience in the procedures, techniques and professional judgements required in the application of each parameter delineated in objective (a) above.
   c. Knowledge of actions, toxicities (adverse reactions), indications and contra-indications of pharmaceutical agents used in the clinical care of eye diseases.
   d. Knowledge of actions, toxicities (adverse reactions), indications and contra-indications of pharmaceutical agents used systemically which potentiate secondary affects upon the eye and vision.
2. To evaluate, examine and certify practitioner skills and competencies in the comprehensive care of eye disease.

PRE-REQUISITES:

1. Graduate of accredited school or college of optometry.
2. Minimum 60 hours of pharmacology education.
3. Pre-assessment evaluation in the following areas:
   a. Basic concepts in pharmacology.
   b. General knowledge of ocular anatomy and physiology.
   c. Applied skills in ophthalmic examination techniques and instrumentation.
4. Pre-course tutorials where indicated from number 3 above.

COURSE SCHEDULE: (See Attachment #1)

ATTACHMENT 1

SCHEDULE

OCULAR THERAPY FOR THE OPTOMETRIC PRACTITIONER

WEEK-END #	DATES	LOCATIONS	COURSE CURRICULUM	FACULTY	HOURS		TUITION			
					LECTURE	CLINIC	GEN.	ADVANCED* A	ADVANCED* B	ADVANCED* C
1	Fri. Sat. Sun.		Pharmacology Tutorial Ocular Pharmacology Anterior Segment Disease	Ph.D. Ph.D. O.D.	(3) 6 6		• • 120	• •	• •	• •
2	Fri. Sat. Sun.		Ocul. Anat. & Physio. Tutorial Anterior Segment Disease Ocular Pharmacology	O.D. O.D. Ph.D.	(3) 6 6		• • 120	• •	• •	• •
3	Fri. Sat. Sun.		Clinical Tutorial Anterior Segment Disease Clinic " " " "	O.D. Full Clinic Staff		(3) 8 7	N/A	• • ↓ 215	• •	• •
4	Fri. Sat. Sun.		Pharmacology Tutorial Systemic Pharmacology Glaucoma	Ph.D. Ph.D. O.D.	(3) 6 6		• • 120	• •	• •	• •
5	Fri. Sat. Sun.		Ocul. Anat. & Physio. Tutorial Anterior Segment Disease Systemic Disease	O.D. O.D. M.D.	(3) 6 6		• • 120	• •	• •	• •
6	Fri. Sat. Sun. Sun.		Clinical Tutorial CPR/Trauma Systemic Procedures Examination, Part I	O.D. EMT & M.D. M.D.	 3	(3) 6 3	N/A	• • ↓ 215	• • ↓ 385	• •
7	Sat. Sun.		Systemic Pharmacology Ocular Neurology	Ph.D. O.D.	6 6		135			
8	Sat. Sun.		Anterior Segment Disease Glaucoma	O.D. O.D. & M.D.	6 6		135			
9	Sat. Sun.		Glaucoma and Anterior Segment Disease Clinic	Full Clinic Staff		8 7	N/A	↓ 245		
10	Sat. Sun.		Cataract/Trauma Posterior Segment Disease	M.D. M.D.	6 6		135			
11	Sat. Sun.		Anterior Segment Disease Posterior Segment Disease	O.D. M.D.	6 6		135			
12	Fri. Sat. Sun. Sun.		Curriculum Review Posterior Segment Procedures " " " Examination, Part II	O.D. Full Clinic Staff	(3) 3	 6 3	N/A	• • ↓ 245	• • ↓ 440	• • ↓ 740
12	31		TOTALS	50	102	48	1020	920	825	740

*Advanced A • Preregistration for first quarter only (first 3 weekends)
" B • " " first half only (first 6 weekends)
" C • " " entire program (all 12 weekends)

** Tutorial and Review tuition additional (not included in course registration). Rate for 3 hour session shall be $25.00 per person with minimum group size of 5 and maximum size of 10.

ANALYSIS OF CURRICULA ELEMENTS

I. Total Course Curricula . . . . . 150 Hours

A. Didactic (Lecture) . . . . . .96 Hours

B. Clinical ("Hands-on") . . . . . .48 Hours

C. Examinations . . . . . 6 Hours
1. Part I (Midterm). . . . . 3 Hours
2. Part II (Final) . . . . . 3 Hours
3. Clinical Evaluation by Instructors

II. Didactic Curricula . . . . . 102 Hours

A. Pharmacology . . . . . 24 Hours
1. Ocular . . . . . 12 Hours
2. Systemic . . . . . 12 Hours

B. Anterior Segment Disease . . . . . 30 Hours

C. Glaucoma . . . . . 12 Hours

D. Systemic Disease . . . . . 6 Hours

E. Trauma & Emergency Care . . . . . 3 Hours
1. Emphasis in clinical portion
2. Also included in Anterior Segment, Pharmacology and Posterior Segment discussions.

F. Ocular Neurology . . . . . 6 Hours

G. Cataract . . . . . 3 Hours

H. Posterior Segment . . . . . 12 Hours

I. Examinations. . . . . 6 Hours

III. Clinical Curricula . . . . . 48 Hours

A. Anterior Segment Disease . . . . . 21 Hours

B. Glaucoma . . . . . 10 Hours

C. Systemic Procedures . . . . . .3 Hours
1. Includes laboratory workup
2. Neurological examination
3. Cardiovascular tests and procedures

D. Trauma & Emergency Care . . . . . 6 Hours
1. CPR Course included

E. Posterior Segment Disease . . . . . 8 Hours
1. Includes Binocular Indirect Ophthalmoscopy

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

June 1, 1981

The Honorable Donald C. Clocksin
Chairman, Health, Education and
Social Services Committee
Alaska State House of Representatives
Room 110 Capitol Building
Juneau, Alaska 99811

Dear Representative Clocksin:

On May 30, I was authorized by the Alaska Optometric Association to enter into negotiations with the Pennsylvania College of Optometry to determine how they might best provide the attached course in primary care ocular therapeutics to Alaskan optometrists.

Under HB 111, ODs would be able to put this training to use. Under CSSB 136, this training could not be used because the bill restricts optometrists to diagnostic usage of ophthalmic drugs.

Since this training represents substantial time and expense to our practicing ODs, including the probability of taking a portion of the training at the Eye Institute in Philadelphia, I would like your opinion as to the probability of HB 111 in its present enabling form receiving approval by the House, or indeed by both houses, during the tenure of the Twelfth Legislature.

I realise you have many matters to consider, but this bill affects potentially every citizen in the state, and is in no sense a parochial issue.

Please call me collect at 276-8120 if a telephone conversation would be more convenient for you than a letter.

Thank you.

Respectfully yours,

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

PWB/lr

Attachment

cc: Senator Parr ✓

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 08.72.050(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.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE BILL NO. 136

"An Act relating to the practice of optometry, and authorizing the use of opthalmic drugs by optometrists."

This bill would permit the use of selected drugs by certain optometrists and as such would delete from the definition of optometry the restriction against the use of drugs. All of these are drugs which are instilled directly into the eye.

In addition to topical anaesthetics, drugs used in examining the human eye include:

Mydriatics - cause pupil to open;

Myotics - cause pupil to close down;

Cycloplegics - cause temporary paralysis of the muscles controlling the shape of the lens.

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

Those opposing permissive legislation argue that the use of drugs would not materially improve the capacity of optometrists to recognize abnormalities. Optometrists are not expected to diagnose diseases of the eye, and if a departure from normal is noted, the patient is expected to be referred to a physician for diagnosis. The concern on the part of the medical community is that the optometrists would be making diagnostic judgments which the physicians do not believe them qualified to make. Moreover, the medical community notes that adverse reactions, while admittedly rare for certain of the drugs, can have extremely serious consequences when they do occur. A higher rate of predisposition to a certain type of glaucoma in Alaska Natives is cited. Use of mydriatics could possible precipitate an attack.

Limitations are placed on the use of certain drugs by the permissive legislation of some states. None are described in the proposed Alaska bill. In Oregon, for example, the Board of Optometry is empowered to designate the diagnostic pharmaceutical agents for topical use, but provides that the designation shall be with the advice and guidance of

POSITION PAPER/Department of Health & Social Services

the Board of Medical Examiners for the State of Oregon. Rhode Island permits the use of mydriatics, miotics and topical anaesthetics while Maine permits only the use of topical anaesthetics and mydriatics. A bill which has been considered in the Ohio legislature specifically prohibits use of pilocarpine (a drug which constricts the pupil), atropine and homatropine (drugs which dilate the pupil and temporarily paralyze accommodation of the lens) and 10% phenylephrine (a strong mydriatic).

Some states define the type of training in pharmacology which would be required before an optometrist would be permitted to use diagnostic drugs. SB 136 contains such provisions.

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

Recommended by: David Bruce

David Bruce, Deputy Director

Date: February 24 1981

Approved by: Helen D. Beirne

Helen D. Beirne, Commissioner

Date: 2-26-81

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill No. 136
Title "An Act relating to the practice of optometry, and authorizing the use of drugs..."
Requested by Commissioner's Office Date February 26, 1981

II. FISCAL DETAIL
Agency Affected Department of Health and Social Servic s
Program Category Affected Health/Public Health
BRU, Program, or Subprogram(s) Affected
(Note: If more than one budget compone 's affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

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

POSITIONS

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

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

IV. DATE: February 26, 1981 PREPARED BY David Bruce
AGENCY Division of Public Health
PHONE: 465-3090

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

31-901 (Rev. 12/80

ALASKA STATE MEDICAL ASSOCIATION
4107 Laurel Street, Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891

March 17, 1981

The Honorable Charles Parr
Chairman
Senate HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I am writing to follow up on my previous testimony to your committee, both in person and by teleconference, regarding SB 136. I would also like to make reference to the preliminary compromise between the optometrists and the medical doctors that was worked out last year, and to address the suggested language to amend SB 136 authored by the DHSS.

Diagnostic pharmaceutical agents that could, with proper safeguards, be considered reasonably safe for use by optometrists include a pure mydriatic, such as phenylephrine hydrochloride 2.5% or 5%; combination cyclopelgics and mydriatics, to include tropicamide 1% and cyclopentolate hydrochloride 1%; and a topical anesthetic such as proparacaine 0.5%. This list of drugs would satisfy the economic wishes of those optometrists who wish to expand their practices without unduly endangering the Alaskan public.

The Alaska State Medical Association is strongly opposed to optometrists using therapeutic agents. Medications are expensive when prescribed needlessly, dangerous when prescribed inappropriately, and well outside the scope of training for most optometrists currently practicing in the state. The DHSS amendments included this limitation.

We believe it is very important that the public be given the opportunity to make an informed decision regarding their vision care when an abnormality is detected. We believe it is essential that the patient understand that they are seeing a non-physician in cases where a pathologic condition is suspected. The DHSS amendments assured this.

Since it is the optometrists who are seeking expansion of their definition of their profession, not a limitation on existing practice by the medical profession, we believe it very important that the Legislature protect the public interest. The consistent testimony by members of the public at the recent teleconference was solidly in support of the Legislature moving very slowly, if at all, regarding expansion of the definition of optometry.

We are prepared to provide further information and recommendations regarding this legislation, should you wish to have further information from us.

Thank you for the opportunity to offer testimony on this most important matter.

Yours truly,

David E. Johnson, M.D.
President

cc Rep. Don Clocksin, House HESS

3-20-81 mark-up SB 136 - optometry

use both boards for rxs. (medical/optometric)

language limits to "letterhead" & "shingle"

drug fields [redacted] are very broad

class? strength?

who decides? - law or Board?

(Spence-Hass) drug generic name & by strength by drug-industry process

(Bach) draft does not allow use of therapeutic drugs (which optometrists are being trained to use)

(McKinney) doesn't want to include therapeutic drugs

no section on the "management"

no examination

clinical experience should be necessary (section 7)

Kelly

draft ok.

reg. drugs by dept. H&SS

give exam by H&SS

H&SS should determine exam

likes exam concept more than clinical

control on distribution of drugs (by DH&SS)

refusals:

08.01.125 -

state med. board agreeable to joint regs. — promulgation of

majority, by each board voted on separately

look at Oregon wording

→ w/ "advice & guidance of Medical Board"

USE OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS BY STATE, TYPE, AND CLASSIFICATION

State	Optometric Drugs		Classifications of Drugs Used					
	Diagnostic Only	Diagnostic & Therapeutic	Cycloplegics	Mydiatrics	Topical Anesthetics	Dyes such as Fluorescein	Miotics	None Specifically Listed In Statute or Regulations
Arizona	X		X	X	X			
Arkansas	X		X	X	X	X		
California	X		[illegible]	X	X			
Delaware	X		X	X	X		X	
Florida	X	X						X
Georgia	X							X
Idaho	X							X
Indiana	X							X
Iowa	X		X	X	X			
Kansas	X		X	X	X			
Kentucky	X		X	X	X		X[E]	
Louisiana	X							X
Maine	X			X	X			
Minnesota	X							X
Montana	X		X	X	X	X	X[E]	
Nebraska	X		X	X	X			
Nevada	X		X	X	X		X	
New Jersey	X							X
New Mexico	X							X
North Carolina	X	X						X
North Dakota	X							X
Oregon	X		X	X	X	X	X[E]	
Pennsylvania	X		X	X	X		X	
Rhode Island	X			X	X		X	
South Dakota	X							X
Tennessee	X		X	X	X		X	
Utah	X		X	X	X			
West Virginia	X[x]	X[x]						X
Wisconsin	X		X	X	X	X	X[E]	
Wyoming	X		X	X	X	X	X[E]	
TOTAL	30	3	16	18	18	5	10	

Key
E = In Emergency Use Only x = excludes Oral or Injectible Drugs Source: American Optometric Association (1980)

Memory SB 136

I am writing in regards to SB 136 - on optometry.

I definitely oppose what is being proposed by the optometry profession.

I personally would not feel safe having an optometrist treat me for a condition that should only be handled by an ophthalmologist - eye Dr.

Thanks,

[illegible signature]
1832 Glacier Hwy
Juneau, AK
99801

Charlie — 3-28-81

Phil Bach says that (he called this a.m.) rather than an additional doc on the board of optometry just use "advice & guidance" for establishing drugs & strengths other than the above, he seemed pleased w/ the new drugs

Rocky

P.S.
U mailed a copy to Bach & Wendy today.