ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 8672

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TO: N.D. FROM J.T SB 79

In reviewing House Bill #75 and Senate Bill #79, Section 2, Subsection 08.72.305 - Use of Drugs for Diagnosis, included in the list of drugs proposed to be used is a class of drugs called miotics. This group of drugs is only therapeutic and has no diagnostic use. They are used for treating chronic glaucoma and acute angle closure glaucoma. What is a therapeutic drug doing in a "diagnostic" bill? Mr. George Hall's and Mr. Sternberg's (both Anchorage optometrists) response to this question at the March 1, 1978 meeting of the Legislative Coalition of Health Care Professionals in Anchorage and at the 1978 hearings on a similar bill introduced and defeated last year respectively was: "To take care of angle closure." "To use this as a first aid measure." This is treatment.

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

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

Miotics are a therapeutic class of drugs and are listed incorrectly in the proposed bills as diagnostic drugs. Either the optometrists do not have a thorough understanding of the eye medications, or they are asking the legislators to allow them to treat glaucoma and other eye conditions. The proposed bill lists only broad general categories of the desired eye medications, no specific drug names and concentrations. The classes of drugs include such potent substances as Cocaine, Atropine, Scopolamine, Phenylephrine and Phospholine Iodide. All these drugs when applied to the eye are readily absorbed into the bloodstream and are capable of producing a wide range of total effects.

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

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

Atropine and Scopolamine are cycloplegic agents which paralyze the eye's focusing power and in sufficient doses produce irritability, hallucinations and even coma. Phenylephrin (a mydriatic) has the ability to raise the blood pressure markedly and to alter the rhythm of the heart and has been implicated in deaths in older people through strokes and in children through cardiac arrhythmias. Phospoline Iodide, a miotic which constricts the pupil, is used in the treatment of glaucoma (elevated pressure in the eye) and in certain cases of crossed eyes. The active ingredients are related to the active substance in certain insecticides and nerve gas. This medication has been shown to produce retinal detachments and cataracts.

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

I. EYE HEALTH CARE PROVIDERS OF THE CONSUMING PUBLIC

The American Optometric Association defines an optometrist as:

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

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

1. "Optometry" is the employment of means or methods, <u>other than the use of drugs</u>, for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye:

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

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

Furthermore, this construed dilemma is removed by a landmark decision by Judge James M. Fitzgerald, United States District Judge for Alaska in the Timothy Steele case in Fairbanks, Alaska. This is the case where an optometrist in Fairbanks used a dilating drop and noted an abnormality and did not refer the child to a medical doctor. The following is a direct and full quote of the Judge's conclusion:

> "I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a 'judgment call' but a violation of the governing principles of professional standards.
>
> Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.
>
> I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.
>
> DATED at Anchorage, Alaska, this 20th day of October, 1978."
>
> ss: James M. Fitzgerald
> United States District Judge

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

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

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

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

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

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

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

ECONOMICS (AND PRACTICE)?

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

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

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

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

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

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

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

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

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

It has been said by the optometrists that they would like to use dilating eye drops also in the their bush clinics when they see Alaska natives. A unique situation exists within the native population of Alaska. The incidence of angle closure glaucoma is 1 in 1,800, not 1 in 20,000 as in caucasions. To allow the optometrist to use these dilating eye drops would result in many more cases of acute angle closure glaucoma, for which they are not trained to treat, and which requires quick and effective treatment to prevent blindness. Sometimes angle closure glaucoma requires administration of intravenous Diamox, Manitol or urea. This would result in further expenditure of health care dollars.

III. LEGISLATIVE DUTY FOR THE EYE CARE CONSUMER:

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

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

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

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

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

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

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

"...regulate the practice of medicine and surgery and the sale of drugs and medicines."[23]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1) The members of the Board of Optometry have little personal experience in ocular pharmacology, ocular pathology, and diagnosis. They are themselves graduate of optometry schools which have offered limited training because the board members took their training when little time was devoted to course work in pharmacology, and now have little experience with drugs. It is difficult to see how such a Board can adequately evaluate such clinical ability in optometric applicants for licensure, nor is it clear how such a Board can construct any 'refresher' course that would adequately prepare the optometrist for his broadened responsibilities. What is usually used is a 'canned' course, prepared elsewhere.

2) The ability of the Board to carry out its mandate to protect the public from those few individuals that would use these diagnostic drugs also as theraputic drugs would find themselves in a frustrated position. The Board can do nothing to prevent this and the fine for practicing medicine without a medical license is only $100.00.

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

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

V. CONCLUSION

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

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

1) optometric training must be upgraded substantially enough to provide him with clinical expertise sufficient to satisfy appropriate public expectations of high competencey; or

2) optometrists must work in an association with ophthalmologists close enough to provide for the day-to-day transmission of diagnotic information from the M.D. to the O.D., and allow the latter to obtain practical involvement in treatment rationals and administration. This would be similar to the military, Veterans Administration and Alaska Native Service, where the optometrist use these drugs under the direct supervision of the ophthalmologists.[47]

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

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

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

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

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

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

FOOTNOTES:

1 - Worthen: The Ophthalmologic-Optometric Interface. Transactions of American Academy of Ophthalmology and Otolaryngology *3:OP-155, 1977

2 - Representativ of most ophthalmology residency programs, it is that of the University of Minnesota, Mayo Clinic Graduate School of Medicine. Following graduation from Medical school and a general or specialty internship, the resident enters a program which requires 65 hours a week of ophthalmologic instruction; of this, approximately 8 hours a week is devoted to formal, diadactic lecture, the remainder is clinical or laboratory activity. This weekly schedule continues over a twelve month academic year, for three years. Some of a nine month written home study course administered by the Academy of Ophthalmology. Some programs require an additional one year of ophthalmology. Department of Ophthalmology, University of Minnesota, Mayo Clinic Resident 1974-1977.

3 - Curriculum,University of Minnesota College of Medicine. The basic curriculum required of any candidate for an M.D. degree includes 128 credit hours of 'medical' subjects; this does not includ clinical studies which are specifically directed toward a specialty interest. Although optometrists may agrue that these requirements are not appropriate for them, such an analysis ignores the fact that in expanding their role into the practice of medicine optometrists should be subjected to the same educational requirements. Unfortunately, there is no short-cut to professional competence. This is particularly ture in the rapidly expanding and complex field of medicine. The public has a right to demand strict legislative requirements before practitioners are certified as competent.

4 - Worthen, note 1, OP-158, supra.

5 - Trapnell, The Impact of National Health Insurance on the Use and Spending for Sight Correction Service, 1976. (This study was underwritten by the American Optometric Association, and the Optical Manufactures Association.) It reveals that optical device sales represent 66% of the funds expended for optometric services and 19% of funds expended for ophthalmologist services, at Tabel 1 of the Trapwell Study.

6 - This figure includes $920 million spent for optician and $220 spent by institutions. Those categories of service providers are not included in this discussion since they are not involved in patient care.

7 - This economic impact will be divided not only by optometrist and ophthalmologists, but also by opticians and lens/fram/contact lens manufacturers.

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

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

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

10- Department of Commerce and Occupational Licensing

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

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

13 - Ellstad v. Swayze, 15 Wash. 2d 281, 130 P2d 354 (1942). See also, Ketchum v. King Co. Medical Service Corp., 81 Wash 2d 565, 502 P2d 1197, 1200 (1973)

14 - Swayze, note 13, 353, supra.

15 - Kelly v. Carroll, 36 Wash 2d 482, 219 P2d 79, 90. (1950)

16 - Campbell v. State, Id., at 462

17 - Gellhorn has recently argued that state licensing statutes are in fact attempts by the profession or occupation involved to control competition by means of restrictive admission to practice. Even Professor Gellhorn would admit that the licensing of health professions is necessary and probably rises above such critisism. Gellhorn, The Abuse of Occupational Licensing, 44 University of Chicago L.R.6, 1976.

18 - Semmler v. Oregon State Dental Examiners, 294, U.S.608, 611, (1934);State v. Wilson, 11 Wn. App. 916, 528 P2d 279 (1974)

19 - R.C.W. 18.53.140

20 - Laughney v. Maybury, 145 Wash. 146, 259 P.17 (1927)

21 - Ellstad v. Swayze, note 47, 353, supra, Accord. Dantzler v. Callison, 230 S.C. 75, 94 WE 2d 177, app. dismd. 352 U.S. 939(1956)

22 - Kelly v. Carroll, note 15, 85, supra.

23 - Art. 20, 2

24 - Ellstad v. Swayze, note 13, 353, supra.

25 - State v. Bonham, 93 Wash 489, 161 P 377, 379 (1916)

26 - Kelly v. Carroll, note 22, supra.

27 - State ex rel Fleming v. Cohn, 12 Wash 2d 425, 121 P2d 954 (1942) Accord, State v Hauk, 32 Wash 2d 68;. 203 P2d 693(1949)

28 - 61 Am Jan 2d, Physicians, Surgeons, and other Healers, 19;86 ALR 623, 624

29 - Ex parte Whitly, 144 Cal. 167, 77 P 879 (1904)

30 - "It is enough that...it might be though that the particular legislative measure was...rational..." Williamson v. Lee Optical Co., 348 U.S. 483, 488 (1955), Douglas, J., majority opinion)

31 - See note 15, supra.

32 - Campbell v. State, note 15, supra.

33 - "A law which reduces or prevents any increase in an ...evil tends to safequard the public welfare..." Id. at 462. (emphasis added).

34 - Williamson v. Lee Optical, note 29, supra.

35 - State v. Houck, note 27, 700, supra.

36 - Worthen, note , Op-160, supra.

37 - "...the legislature was careful to require definite knowledge

38 - West Virginia Statute 30-8-5 requires those optometrists who wish to use drugs to complete those requirements which the board of optometry may see fit to extablish. The board of optometry requires attendance at a pharmacology course similar to that described in note 43, infra.

39 - Ellstad v. Swayze, note 13, supra.

40 - Campbell v. State, note 15, supra.

41 - R.C.W. 18.54070

42 - R.C.W. 18.54.030 - In fact, the statute excludes from board membership any optometrist "...who has any connection with any school...of optometry..." It could be presumed that optometrists teaching at optometric schools would be best qualified to judge the qualifications of optometric candidates and possess the most crrency in clinical information.

43 - A letter from Leon Candenb, O.D., Director Pennsylvania College of Optometry describes the lecture outling in pharmacology used by Kentucky, Florida, Pennsylvania and New Mexico. This course involves participation by the optometrist in six weekend sessions (Saturday and Sunday) and ends with a three hour examination covering the presented material. A letter from Sam A. McConkey,M.D to the Honorable Charles Parr:

ON OPTOMETRISTS PRACTICING IN THE STATE OF ALASKA

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

24 attended Pacific University College of Optometry(1951-1976)
5 attended Illinois College of Optometry (ICO)
4 from 1948 to 1960 and 1 graduated in 1977
3 attended Southern College of Optometry
2 attended the University of Houston College of Optometry
1 attended Southern California College of Optometry
1 attended Los Angles College of Optometry (No longer listed as an optometric school)
1 attended Northern Illinois College of Optometry (No longer listed as an optometric school)
In one case, it is unkown to the Department of Commerce where he went to school.

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

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

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

Southern College of Optometry has NO M.D., PhD., or anyone with a masters or bachelors degree in pharmacology teaching at that institution.
University of Houston College of Optometry has NO M.D., PhD., or anyone with a masters or bachelors degree in pharmacology teaching at that institution.
Southern California College of Optometry has NO M.D. teaching in pharmacology; has two instructors listed as either a PhD. or masters or bachelors degree.

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

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

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

44 - State v. Spino, 61 Wash 2d 246, 377 p2d 868, 870 (1963)

45 - Pennington v. Benelli, 15 Cal App 2d 316, 59 P2d 449

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

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

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

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

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

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

TABLE I

SYMPOSIUM ON LEGISLATION

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

Comparison of Optometry and Ophthalmology

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

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

** 126 hours - Southern College of Optometry

*** Mayo Clinic and Iowa

TABLE 1A

OPTOMETRIC EDUCATION DEFICIENCY DOCUMENTED FOR REDBOOK SURVEY
As prepared by John W. Gamel, M. D.
University of Louisville School of Medicine

EDUCATIONAL BACKGROUND REQUIRED FOR DELIVERY OF EYE CARE:

Comparison between Optometry and Ophthalmology*

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

*Information abstracted from:

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

TABLE Ib

BREAKDOWN OF HOURS SPENT IN EDUCATION OF OPTHALMOLOGIST

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

RESIDENCY TRAINING SCHEDULE, DEPARTMENT OF OPHTHALMOLOGY
UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

Summary of Hours of Didactic Learning Offered During Residency:

Ongoing Lectures:

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

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

Home Study Course:
20 hrs per month
Duration: 24 months

TABLE 2

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

Service offered by Optometrist and Ophthalmologist

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

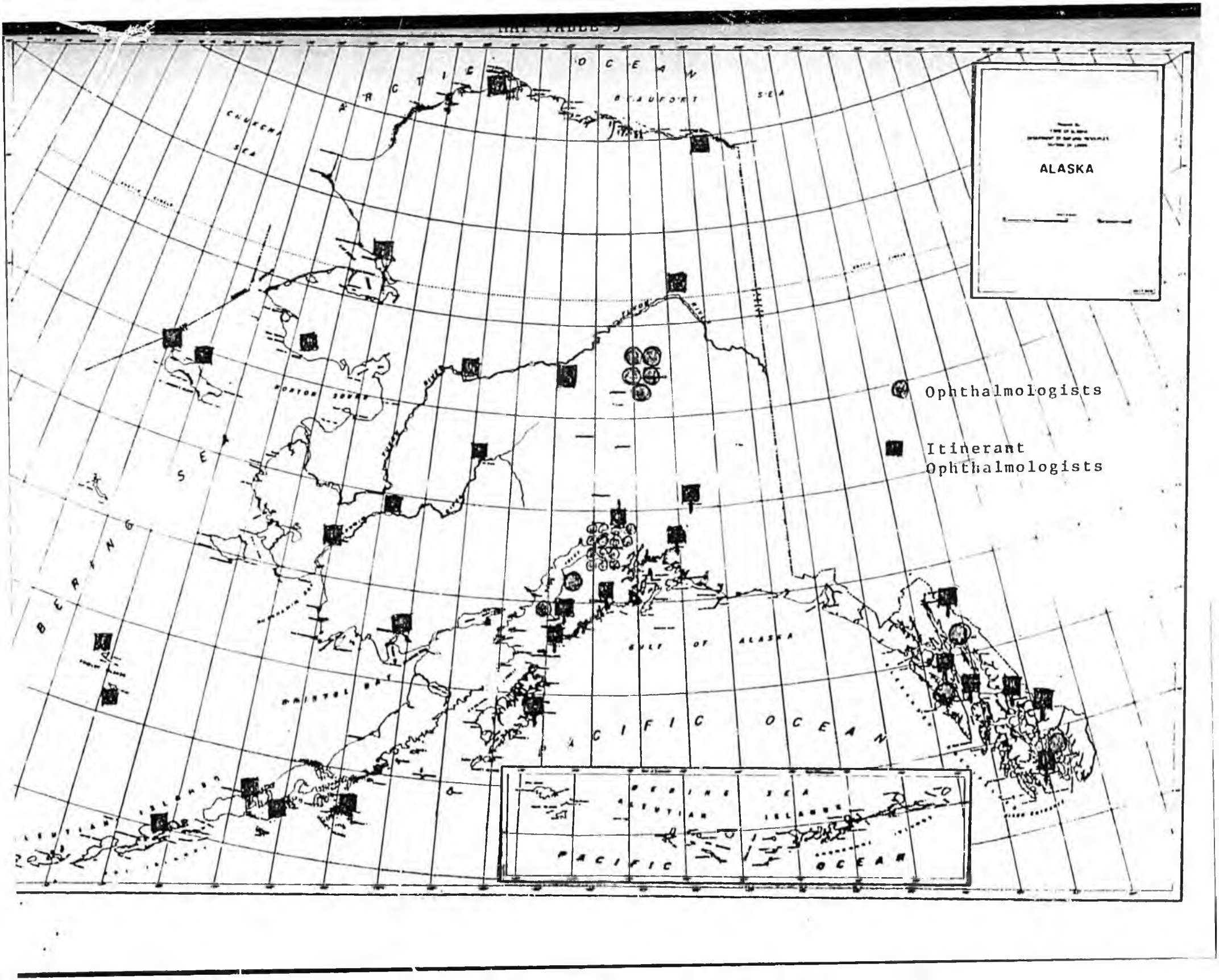

ALASKA
Ophthalmologists
Itinerant Ophthalmologists
ARCTIC OCEAN
BEAUFORT SEA
CHUKCHI SEA
BERING SEA
GULF OF ALASKA
PACIFIC OCEAN
ALEUTIAN ISLANDS

TABLE 3

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

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

Reprinted from

Virginia Medical

November, 1979

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 stone and could well be combined, i.e., if a patient states that he does not see well, and if his visual acuity is indeed decreased, then the patient's history is confirmed. In 610 (85.2%) of the 716 patients with disease, this triad

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

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

indicated visual system disease. Refracting four high myopes or noticing thick spectacle lenses would have indicated the need for careful indirect 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 choroidal nevus was known to her from an examination about one year prior, she did not reveal this to the examiner initially.

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

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.

THE PEN...—

WHO TEACHES OPTOMETRISTS MEDICINE?

CURRENT SCHOOL CATALOG STUDY COMPARES FACULTIES AT SEVERAL TYPICAL MEDICAL AND DENTAL SCHOOLS WITH FACULTIES AT *ALL* OPTOMETRY SCHOOLS IN THE U.S.

MEDICAL COLLEGES	Total # of Students	Total # of Faculty	Faculty Student Ratio	Total # of M.D. Professors (Full or Part Time)	Full Time Clinical* Teaching M.D. Specialists	OPHTHALMOLOGISTS (M.D. Eye Specialists)			PHARMACOLOGY DEPARTMENT		O.D.s	O.D./Ph.D.	Other Ph.D., M.S. or B.S.	COMMENTS
						Full Time	Part Time	M.D. Residents	M.D.s - M.D./Ph.D.	Ph.D., M.S. or B.S.				
Medical University of South Carolina College of Medicine	660	1,281	1 [illegible]	651	201	3	23	9**	6	25	0	0	630	* *CLINICAL* — Refers to working with patients in hospitals or out-patient clinics ** Ophthalmology Residents spend 3 months during their 3-year residency in an intense basic science course taught by nationally prominent Opnthalmologists at Colby College, Waterville, Maine
Duke University College of Medicine	489	1,102	2.3	632	483	8	10	16	2	7	0	0	470	
Medical College of Georgia	720	944	1.3	495	246	3	10	8**	2	10	0	0	449	
DENTAL COLLEGES														
Medical University of South Carolina College of Dentistry	160	312	2.0	74	0	0	0	0	6	25	0	0	123	84 D.D.S. teaching mostly Clinical 9 are D.D.S., Ph.D.
Medical College of Virginia College of Dentistry	439	353	.80	33	0	0	0	0	8	20	0	0	127	126 D.D.S. teaching mostly Clinical 20 are D.D.S., Ph.D.
COLLEGES OF OPTOMETRY														
Southern College of Optometry	604	49	.08	2 PART TIME	0	0	0	0	0	0	37	2	7	The 2 part time M.D.s are classroom lecturers in Pathology.
Illinois College of Optometry	600	56	.09	1 PART TIME	0	0	0	0	0	1	47	1	6	The only M.D. is a part time Lecturer in Pathology.
Pennsylvania College of Optometry	552	89	.16	5 PART TIME	0	0	2	0	0	1	55	4	17	
Southern California College of Optometry	384	83	.22	5 PART TIME	0	0	2	0	0	2	65	5	8	
Pacific University College of Optometry	340	23	.07	1 PART TIME	0	0	0	0	0	0	12	1	8	The only M.D. is a Professor of Physics and Optics, part time.
New England College of Optometry	332	66	.20	4 PART TIME	0	0	2	0	0	1	52	5	4	
University of Houston College of Optometry	284	64	.23	2 PART TIME	0	0	0	0	0	0	47	4	7	The 2 part time M.D.s are Classroom Lecturers in Pathology.
Indiana University College of Optometry	276	38	.14	0	0	0	0	0	0	0	21	4	11	No M.D.s on Staff.
Ohio State College of Optometry	228	63	.28	1 PART TIME	0	0	1	0	0	0	46	4	12	The only M.D. is part time. He lives 100 miles away in Cincinnati.
University of Alabama College of Optometry	140	48	.30	3 PART TIME	0	0	0	0	1	0	22	9	12	All M.D.s are part time classroom lecturers. One M.D./Ph.D. lectures in Pharmacology.
State University of New York College of Optometry	160	122	.76	9 PART TIME	0	0	6	0	0	0	87	3	22	
University of California Berkeley College of Optometry	256	77	.30	9 PART TIME	0	0	6	0	0	0	43	11	12	One part time M.D. teaches in Public Health, one in Engineering and one in Physiological Optics
Ferris State College of Optometry	100	31	.31	0	0	0	0	0	0	3	1	0	29	All but 2 of these 29 also teach in the Biology and Chemistry departments of the Undergraduate College.

CAN MEDICAL EYE CARE BE ENTRUSTED TO OPTOMETRISTS WHEN THIS STUDY PROVES THAT THERE ARE *NO* FULL-TIME M.D. INSTRUCTORS IN ANY OPTOMETRY SCHOOL ANYWHERE?

Study Compiled for PEN Inc. by the EDUCATIONAL CATALOG STUDY COMMITTEE OF THE SOUTH CAROLINA OPHTHALMOLOGICAL SOCIETY DECEMBER, 1977.

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

STATE OF ALASKA
FISCAL NOTE

Revision Date 4/12, 1983

I. REQUEST

Bill/Resolution No.: SB 189
Title: "Optometrist - Use of Drugs"
Sponsor: Josephson
Requestor: HESS Committee

II. FISCAL DETAIL

Agency Affected: Commerce & Econ. Devp.
Program Category Affected: Public Prot.
BRU, Program of Subprogram(s) Affected:
Occupational Licensing

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES		31.6	33.1	34.6	36.2	37.9
200 TRAVEL		2.0	2.1	2.2	2.4	2.5
300 CONTRACTUAL		1.5	1.6	1.7	1.7	1.8
400 COMMODITIES		0.5	0.5	0.6	0.6	0.6
500 EQUIPMENT		2.7	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL OPERATING		38.3	37.3	39.1	40.9	42.8
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		38.3	37.3	39.1	40.9	42.8
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS:

FULL-TIME		1	1	1	1	1
PART-TIME						
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

Not identified by sponsor.

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Darrell Miller (Darrell Miller) Phone: 465-2535
Division: Occupational Licensing Date: 4/12/83

Approved by Commissioner: Richard A. Lyon Date: 4/13/83
Department: Commerce & Economic Development

Distribution:
Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
Copy to Department (for Governor introduced bills)
Copy to Sponsor
Copy to Requestor (if different from Sponsor)

3/8/83

SB 139 FISCAL IMPACT

(Note: 5% inflation factor projected for FY '84 through FY '88 for operating cost)

100 PERSONAL SERVICES - (FY '83 salary schedule plus 5% inflation factor)

1 Licensing Examiner, Range 12A, General Government, 12 months, to be located in Juneau	$31,502.00

200 TRAVEL

4 board meetings annually (2 days each @ $80.00/day per diem = $160.00 x 4)	$ 640.00
Transportation - board meetings annually ($350.00 each x 4)	1,400.00
	$ 2,040.00

300 CONTRACTUAL

Postage, telephone, printing, publications and operating costs	$ 1,500.00

400 COMMODITIES

Stationery, typewriter ribbons, pens, pencils, and other miscellaneous desk top supplies	$ 500.00

500 EQUIPMENT (One time cost, FY '84 only)

1 desk, double pedestal, 60" x 30"	$ 427.00
1 chair, swivel w/arms	202.00
1 typewriter, IBM Selectric II	1,129.00
1 typewriter table	94.00
1 chair, side, without arms	104.00
1 desk calculator	332.00
1 book case	138.00
1 file cabinet, 4 drawer, legal with lock	306.00
	$ 2,732.00

One position total:	$38,374.00

(c) An endorsement under (b) of this section shall expire with the license to which it attaches and may be renewed upon evidence of satisfactory completion of a continuing education program specified and approved by the board for holders of this type of endorsement under (a) of this section.

(d) The board shall adopt regulations concerning the use or prescription of legend drugs and may revoke or suspend a license endorsement for their use and prescription for violation of the regulations.

(e) The board shall furnish to the board of pharmacy the names of all holders of endorsements issued under this section.

* Sec. 3. AS 08.72.300(2) is amended to read:

(2) "optometry" is the examination [, OTHER THAN BY THE USE OF DRUGS,] 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 diagnosis and treatment, including the use of drugs, of inflammations, infections, and injuries of the anterior segment of the eyes and eyelids; [,] or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

* Sec. 4. AS 08.72.300(3) is amended to read:

(3) "practicing optometry" is an examination [, OTHER THAN BY THE USE OF DRUGS,] 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

* Sec. 5. AS 08.72.300 is amended by adding a new paragraph to read:

~~(7) "legend drugs" means drugs whose containers must bear a label prohibiting dispensing without a prescription~~.

* Sec. 6. AS 08.64.360 is amended to read:

Sec. 08.64.360. PENALTY FOR PRACTICING WITHOUT A LICENSE OR IN VIOLATION OF CHAPTER. Except for a physician assistant, an optometrist, and a physician-trained mobile intensive care paramedic under AS 08.64.170, a person practicing medicine or osteopathy in the state without obtaining and filing an appropriate license is guilty of a misdemeanor and upon conviction is punishable by a fine of not less than $50 nor more than $100, or by imprisonment for not less than 10 days nor more than 90 days, or by both. Evidence that the defendant has failed to file a license with the clerk of the court is prima facie evidence that the defendant is not licensed. Each day of illegal practice is a separate offense.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

OPTOMETRISTS AND EXPLANATIONS

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

May 1, 1983

The Hon. Joe Josephson
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Sen. Josephson: re: SB 189

The attached list of drugs comprising an addition to the proposed committee substitute for SB 189 previously submitted to you needs some explanation:

These drugs will allow us to do an effective job of primary eye care. The most important of these drug groups are (1) the anti-infectives, which combat bacterial infections and will allow us to treat "pink eye" (conjunctivitis) and prevent infection secondary to contact lens overwear abrasions; (2) the anti-inflammatories (steroid eye drops) that reduce inflammation and promote more orderly healing in non-infective inflammations such as severe allergic reactions from exogenous sources; and (3) the anti-glaucomals, which we would use primarily in the emergency treatment of acute glaucoma (elevated fluid pressure within the eye), which cannot wait for referral to an ophthalmologist. For phenylephrine, a 2.5% strength has been specified; it also comes in a 10% concentration. While the latter gives better pupil dilation, it is contraindicated in persons with heart disease.

Here are some other salient background items: mydriatics/cycloplegics dilate the pupil (mydriasis), block the near focus of the eye (cycloplegia), or both. Mydriasis permits better examination of the peripheral retina, particularly when the pupil is small or there is a developing central cataract. Cycloplegia sometimes aids in refractive testing of farsighted individuals. Topical anesthetics allow the most accurate measurement of the fluid pressure within the eye (tonometry). They also enable an injured eye to be examined, and permit removal of superficially embedded foreign bodies.

This drug list is based on the attached formulary prepared by Dr. Louis J. Catania, a faculty member of the Pennsylvania College of Optometry and an instructor in the postgraduate therapeutics course most Alaskan ODs took from that institution last year.

A drawback of listing drugs in statute is that new legislation is required every time a new drug comes out. A better law, in my opinion, is the West Virginia statute, on which West Virginia's

excellent track record is based. A copy of the West Virginia statute is attached. It limits drugs to those which are topically applied (drops or ointments, as opposed to oral or injectible drugs), but allows the board of examiners in optometry to approve or disallow specific drugs within that category.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
Legislative Committee
Alaska Optometric Association

* Sec. 6. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.305. Legend drugs permitted. A licensee holding a certificate issued under AS 08.72.277 may employ or prescribe only those legend drugs specified under the following classifications:

(a) Topical anesthetics

(1) Benoxinate

(2) Proparacaine

(b) Anti-infectives

(1) Bacitracin

(2) Chloramphenicol

(3) Erythromycin

(4) Gentamycin

(5) Polymixin B

(6) Sulfacetamide

(7) Tetracycline

(8) Tobramycin

(c) Anti-glaucoma agents

(1) Acetazolamide

(2) Epinephrine

(3) Pilocarpine

(4) Timolol

(d) Antihistamines

(1) Antazoline

(2) Pyrilamine

(e) Anti-inflammatory agents

(1) Dexamethasone

(2) Flurometholone

(3) Hydrocortisone

(4) Prednisolone

(f) Antivirals

(1) Idoxuridine

(2) Trifluridine

(3) Vidarabine

(g) Decongestants

(1) Naphazoline

(h) Hyperosmotics

(1) Sodium Chloride 2%, 5%

(2) Glycerin

(i) Mydriatic/Cycloplegics

(1) Cyclopentolate

(2) Homatropine

(3) Phenylephrine 2.5%

(4) Tropicamide

Note: This replaces Section 6 in the proposed committee substitute previously submitted and in the original bill. The original section 6 will not be needed if the new medical practice act (CSSB 164) is enacted.

SUGGESTED FORMULARY OF IN-OFFICE OPHTHALMIC PHARMACEUTICALS

Prepared by - Louis J. Catania, O.D.

CATEGORY	GENERIC NAME	BRAND NAME	CONCENTRATION(S)
Anesthetics	Benoxinate	Fluress	0.4%
	Proparacaine	Ophthaine	0.5%
Antiglaucoma	Acetazolamide	Diamox	250 mg.
	Glycerin	Osmoglyn	50%
	Pilocarpine	Isoptocarpine	1,2,& 4%
	Timolol	Timoptic	0.25 & 0.50%
Antihistamines	Antazoline	Vasocon	1%
Anti-infectives	Sulfacetamide	Isoptocetamide	15%
	Gentamicin	Garamycin	0.3%
	Chloramphenicol	Chloroptic	1%
	Tobramycin	Tobrex	0.3%
	Tetracyline	Achromycin	1%
	Erythromycin	Ilotycin	5 mg/3.5g
	Zinc sulfate	Zincfrin	0.25%
-(Combinations)	Sulfacetamide/Prednisolone	Blephamide	10%/0.2%
	Polymyxin B/Bacatracin	Polysporin	10000/500 units
- Antivirals	IDU	Stoxil	0.5%
	Vidarabine	Vira A	3%
	Trifluridine	Viroptic	1%
- Antifungals	Natamycin	Natacyn	5%
Artificial Tears	Mucomimetics	Hypotears	
	Ointments	Lacrilube	
Corticosteroids	Prednisolone	Pred Forte	1%
	Fluoromethalone	FML	0.1%
	Dexamethasone	Decadron	0.1%
	Hydrocortisone	Hytone	0.5%, 1%
Decongestants	Naphazoline	Vasoclear	0.02%
	Phenylephrine	Prefin	0.12%
-Combination	Naphazoline/Zinc Sulfate	Vasoclear-A	0.02%/0.25%
Dyes	Sodium Fluorescin	Barnes Hind Sterile Strips	0.6 mg.
	Rose Bengal	" " "	1%
Hyperosmotics	Sodium Chloride	Adsorbonac	2, 5%
	" " Oint.	Muro #128	5%
Irrigations	Buffered Solution	Dacriose	0.9%
	" Saline	Eye Stream	0.9%
Mydriatic/Cycloplegias	Cyclopentolate	Cyclogyl	0.5, 1 & 2%
	Homatropine	Isoptohomatropine	2 & 5%
	Tropicamide	Mydriacyl	0.5 & 1%
	Phenylephrine	Neosynephrine	2.5%
	Hydroxyamphetamine	Paradrine	1%

imposed by the board and embodied in the board's certificate or order of revocation or suspension.

18.54.110 Suspension or revocation of license for unprofessional conduct—Judicial review. Any person whose license has been revoked or suspended may seek judicial review of the board's action or decision under the provisions of chapter 34.04 RCW as amended from time to time.

18.54.120 Reinstatement. Any person whose license has been revoked or suspended may apply to the board for reinstatement at any time; and the board may hold hearings on such petition, may impose such terms or conditions as are appropriate under the circumstances, and may order a reinstatement.

9.04 False advertising.

69.33 Narcotics.

18.54.150 Powers previously vested in director of licenses under RCW 18.53.100 now vested in optometry board.

70.96A Uniform alcoholism and intoxication treatment act.

West Virginia Optometry Law

30-8-1. EVIDENCE OF QUALIFICATION TO PRACTICE AND REGISTRATION REQUIRED.—Any person practicing or offering to practice optometry in this State shall be required to submit evidence that he is qualified so to practice, and shall be registered as hereinafter provided, and it shall be unlawful for any person to practice or offer to practice optometry in this State, except under the provisions of this article.

30-8-2. PRACTICE OF OPTOMETRY DEFINED.—Any one or any combination of the following practices shall constitute the practice of optometry:

(a) The examination of the human eye, with or without the use of drugs, prescribable for the human eye, which drugs may be used for diagnostic or therapeutic purposes for topical application to the anterior segment of the human eye only, and, by any method other than surgery, to diagnose, to treat or to refer for consultation or treatment any abnormal condition of the human eye or its appendages;

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

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

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

30-8-3. BOARD OF OPTOMETRY, DUTIES.

30-8-3a. REGISTRATION OF OPTOMETRIC CORPORATIONS.

30-8-3b. PRACTICE OF OPTOMETRY BY OPTOMETRIC CORPORATIONS.

30-8-4. REGISTRATION PREREQUISITE TO PRACTICE OF OPTOMETRY; EXCEPTIONS.—No person shall practice or offer to practice optometry in this State without first applying for and obtaining a certificate of registration for such purpose from the West Virginia Board of Optometry; but the following persons, firms and corporations are exempt from the operation of this article, except as hereinafter provided:

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

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

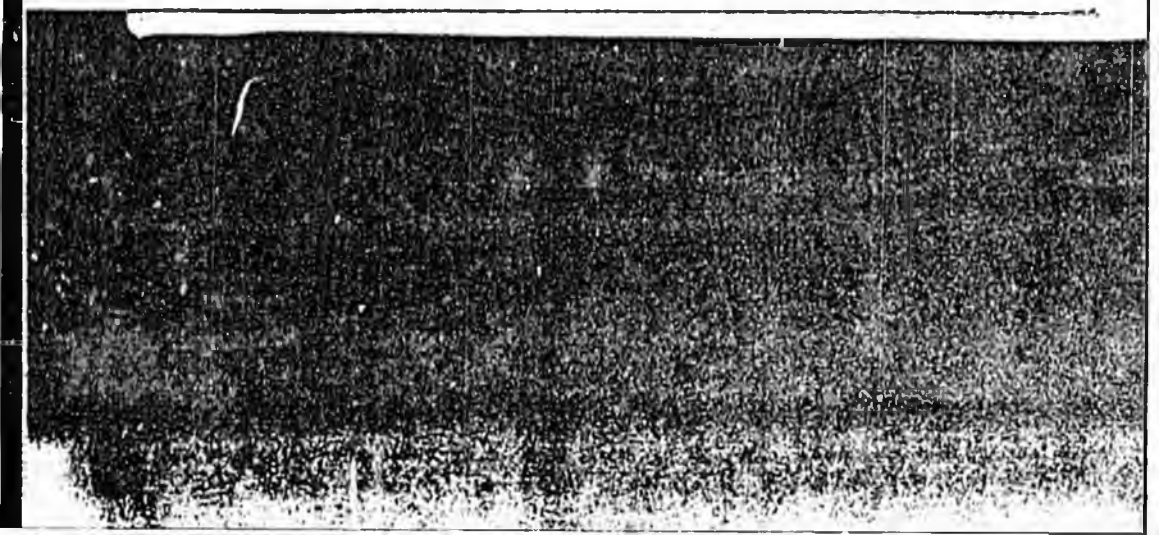
(c) Persons, firms and corporations who sell eye glasses or spectacles in a store, shop or other permanently established place of business on prescriptions from persons authorized under the laws of this State to practice either optometry or medicine and surgery;

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

30-8-5. QUALIFICATIONS OF APPLICANT FOR REGISTRATION, EXAMINATION.—An applicant for registration shall present satisfactory evidence that he is at least eighteen years of age, of good moral character and temperate habits, and has graduated from a high school or secondary school, or has completed an equivalent course of study approved by the West Virginia board of optometry, has satisfactorily completed all preoptometry or premedical college requirements and has graduated from a school or college of optometry approved by said board. No school or college of optometry shall be approved by the West Virginia board of optometry unless at first it has been accredited by a regional or professional accreditation organization which is recognized by the national commission on accreditation or the United States commission of education. Each applicant shall submit to and be examined in all phases of optometry as is provided by the school or college of optometry and shall include, but not be limited to, anatomy and physiology of the human eye, the use of instruments such as the ophthalmoscope, retinoscope, tonometer, slit lamp biomicroscope, the general laws of optics and refraction, general and ocular pharmocology, general and ocular pathology and other such subjects or instrumentation as the board of optometry may deem necessary.

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

30-8-6. CERTIFICATE OF REGISTRATION OR EXEMPTION SHALL BE DISPLAYED; BILL OF PURCHASE. Every person practicing optometry shall display his certificate of registration or exemption in a conspicuous place in the principal office wherein he practices optometry, and, whenever required, shall exhibit such certificate to the board of examiners or its authorized representatives. And whenever practicing the profession of optometry outside of or away from said office or place of business, he shall deliver to each customer or person so fitted with glasses a bill of purchase which shall contain his signature, home post-office address, and the number of his certificate of registration or exemption, together with a specification of the lenses furnished.



30-8-7. ANNUAL RENEWAL OF REGISTRATION; RESTORATION OF EXPIRED CERTIFICATE. Every registered optometrist who desires to continue in active practice or service shall, annually, on or before the first day of August, of each year, renew his certificate of registration, and pay an annual renewal fee of twenty dollars. Every certificate of registration which has not been renewed during the month of August in any one year shall expire on the first day of September of that year. A registered optometrist whose certificate of registration has expired may have the same restored only upon payment of the required renewal fee. Any registered optometrist who retires from the practice of optometry for more than five years may renew his certificate of registration upon payment of all lapsed renewal fees.

30-8-8. REFUSAL TO ISSUE, SUSPENSION OR REVOCATION OF CERTIFICATE; FALSE AND DECEPTIVE ADVERTISING. The Board may either refuse to issue, or may refuse to renew, or may suspend or revoke any certificate of registration for any one, or any combination, of the following causes: Violation of a rule or regulation governing the ethical practice of optometry promulgated by the Board under the authority granted by this article; conviction of a felony, as shown by a certified copy of the record of the court wherein such conviction was had; the obtaining of, or the attempt to obtain, a certificate of registration, or practice in the profession of optometry, for money, or any other thing of value, by fraudulent misrepresentation; gross malpractice; continued practice by a person knowingly having an infectious disease; habitual drunkenness, or addiction to the use of morphine, cocaine, or other habit-forming drugs; advertising, practicing, or attempting to practice under a name other than one's own; advertising by means of knowingly false or deceptive statements. All advertising, whether by means of newspapers, or in any manner, whatsoever, of the following statements, or statements of similar import, that are "false and deceptive" within the meaning of this law, shall be prohibited. False and deceptive advertising shall include but not be limited to the following: (a) Advertising of complete glasses, that is to say, lenses and frames or mountings, at a stated price, either alone or in conjunction with professional services; (b) advertising "free examination of eyes", or "free consultation", or "free advice", or words of similar import and meaning; (c) advertising frames or mountings for glasses, by advertisement which does not accurately describe the same in all its component parts (all such advertisements shall state clearly, in type equal in size to the price figures given, that such price does not include cost of lenses, or professional services in examining of eyes), and, (d) advertising a particular sum or sums of money required as a "down" or cash payment, or any definite amount or amounts of future payments, or when the same shall be paid.

30-8-9. OFFENSES; PENALTIES; JURISDICTION OF JUSTICES. Each of the following shall constitute a misdemeanor punishable, upon conviction, for the first offense, by a fine of not less than one hundred nor more than two hundred dollars, and, upon conviction for a second or subsequent offense, by a fine not less than two hundred nor more than five hundred dollars, or by imprisonment for not less than thirty nor more than ninety days, or by both such fine and imprisonment, at the discretion of the court. The practice of, or an attempt to practice optometry, without a certificate of registration as a registered optometrist, except as hereinbefore provided; permitting any person in one's employ, supervision or control, to practice optometry, unless such a person has a certificate of registration as a registered optometrist when such certificate is required by this article; the obtaining of, or an attempt to obtain, a certificate of registration, or practice in the profession, or money, or anything of value, by fraudulent misrepresentation; the making of any willfully false oath or affirmation, whenever an oath or affirmation is required by this article; the violation of the provisions of section six of this article.

Justices of the peace shall have concurrent jurisdiction with circuit and criminal courts for the enforcement of this article.

30-8-10. UNLAWFUL PRACTICE OF OPTOMETRY; PENALTIES.—Any corporation or voluntary association shall not practice, or assume to practice, or in any manner to hold itself out to the public as being entitled to practice the profession of optometry, or advertise the title of optometrist in such a manner as to convey the impression to the public that it is entitled to practice optometry, or furnish optometric advice and services, or advertise that, either alone or together with or by or through any person, whether a duly registered and licensed optometrist or not, it has, owns, conducts or maintains an office or place for practice of optometry. Any duly registered and licensed optometrist shall not associate himself with any corporation or voluntary association for the practice of optometry, or in any manner practice such profession, on a salary or commission basis, for any such corporation or voluntary association. Any corporation or voluntary association violating any of the provisions of this section, or any officer, trustee, director, agent or employee of such corporation or voluntary association who, either directly or indirectly, engages in any of the acts, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not less than one hundred nor more than one thousand dollars. The fact that any such officer, trustee, director, agent or employee shall be a duly registered and licensed optometrist shall not be held to permit or allow any such corporation or voluntary association to do the acts prohibited herein, nor shall such fact be a defense upon the trial of any of the persons hereinbefore mentioned for a violation of this section. Any duly registered and licensed optometrist who shall violate the provisions of this section shall be guilty of a misdemeanor, and upon conviction thereof shall be fined not less than ten dollars nor more than twenty-five dollars, and each and every day such violation continues shall constitute a separate offense; and in addition to the foregoing penalties, such offending optometrist shall have his license to practice suspended for a period of one year, by the court in which such conviction is had; Provided that this section shall not apply to a partnership of two or more duly registered and licensed optometrists who practice under their own names.

It shall be unlawful for any registered optometrist to practice his profession as an employee, lessee, or sub-lessee of any commercial or mercantile establishment or to practice his profession in connection therewith, or to advertise either in person or through any commercial or merchantile establishment that he is a duly registered practitioner, and is practicing or will practice optometry as an employee, lessee, or sub-lessee of any such commercial or mercantile establishment or in connection therewith. But nothing herein shall be construed to prohibit or prevent the rendering of professional services to the officers and employees of any person, firm or corporation by an optometrist, whether or not the compensation for such services is paid by the officers and employees, or by the employer, or jointly by all or any of them. Any person violating this provision shall be guilty of a misdemeanor, and, upon conviction thereof shall be fined not less than fifty nor more than five hundred dollars, and each and every day such violation continues shall constitute a separate offense.

Wisconsin Optometry Law

Optometry

449.01 (1) Optometry. (a) (1) The practice of optometry is defined as follows: The employment of any means including topical ocular diagnostic pharmaceutical agents under S. 449.17, to determine the visual efficiency of human visual system, including refractive and functional abilities or preliminarily diagnose the presence of ocular disease or ocular manifestations of systematic disease and other departures from normal.

(2) The diagnosis and treatment of the refractive and functional ability of the visual system and enhancement of visual performance by prescribing, furnishing, fitting or employing ophthalmic lenses, con-

SB 189

Summary of changes in the substitute bill

1. Excludes injectibles and controlled substances

2. Limits scope of therapeutics practice to anterior segment. Defines anterior segment.

3. Sets specific training requirements (conforms to current educational practice)

By OPTOMETRISTS

IN THE HOUSE BY HURLBERT

HOUSE BILL NO. 225

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

* Section 1. AS 08.64.170(a) is amended by adding a new paragraph to read:

(4) a person licensed under AS 08.72 may use and prescribe legend drugs, as defined in AS 08.72.300, if the person's license is endorsed by the board of examiners in optometry as provided in AS 08.72.

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

Sec. 08.72.277. USE OR PRESCRIPTION OF LEGEND DRUGS. (a) To be eligible to use or prescribe legend drugs, a licensee shall submit proof acceptable to the board that he has completed not less than 100 transcript grade hours of education, training and clinical experience in ocular therapeutics, and passed a written and practical examination in the subject matter. The course or courses shall include the following subjects:

(1) General and ocular pharmacology

(2) Review of ocular pathology and differential diagnosis

(3) Treatment protocols and procedures

This training shall be given by an institution of learning accredited by the Council on Post-Secondary Accreditation or the United States Department of Education, or by a hospital, clinic or other health care facility formally affiliated with such an institution.

(c) An endorsement under (b) of this section shall expire with the license to which it attaches and may be renewed upon evidence of satisfactory completion of a continuing education program specified and approved by the board for holders of this type of endorsement under (a) of this section.

(d) The board shall adopt regulations concerning the use or prescription of legend drugs and may revoke or suspend a license endorsement for their use and prescription for violation of the regulations.

(e) The board shall furnish to the board of pharmacy the names of all holders of endorsements issued under this section.

* Sec. 3. AS 08.72.300(2) is amended to read:

(2) "optometry" is the examination [, OTHER THAN BY THE USE OF DRUGS,] 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 diagnosis and treatment, including the use of drugs, of inflammations, infections, and injuries of the anterior segment of the eyes and eyelids; [,] or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

* Sec. 4. AS 08.72.300(3) is amended to read:

(3) "practicing optometry" is an examination [, OTHER THAN BY THE USE OF DRUGS,] 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

* Sec. 5. AS 08.72.300 is amended by adding a new paragraph to read:

~~(7) "legend drugs" means drugs whose containers must bear a label prohibiting dispensing without a prescription~~.

* Sec. 6. AS 08.64.360 is amended to read:

Sec. 08.64.360. PENALTY FOR PRACTICING WITHOUT A LICENSE OR IN VIOLATION OF CHAPTER. Except for a physician assistant, an optometrist, and a physician-trained mobile intensive care paramedic under AS 08.64.170, a person practicing medicine or osteopathy in the state without obtaining and filing an appropriate license is guilty of a misdemeanor and upon conviction is punishable by a fine of not less than $50 nor more than $100, or by imprisonment for not less than 10 days nor more than 90 days, or by both. Evidence that the defendant has failed to file a license with the clerk of the court is prima facie evidence that the defendant is not licensed. Each day of illegal practice is a separate offense.

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

SB 189

Summary of changes in the substitute bill

1. Excludes injectibles and controlled substances

2. Limits scope of therapeutics practice to anterior segment. Defines anterior segment.

3. Sets specific training requirements (conforms to current educational practice)

Introduced: 2/23/83
Referred: Health,Education &
Social Services

IN THE HOUSE BY HURLBERT

HOUSE BILL NO. 225

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

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(1) General and ocular pharmacology

(2) Review of ocular pathology and differential diagnosis

(3) Treatment protocols and procedures

This training shall be given by an institution of learning accredited by the Council on Post-Secondary Accreditation or the United States Department of Education, or by a hospital, clinic or other health care facility formally affiliated with such an institution.

(c) An endorsement under (b) of this section shall expire with the license to which it attaches and may be renewed upon evidence of satisfactory completion of a continuing education program specified and approved by the board for holders of this type of endorsement under (a) of this section.

(d) The board shall adopt regulations concerning the use or prescription of legend drugs and may revoke or suspend a license endorsement for their use and prescription for violation of the regulations.

(e) The board shall furnish to the board of pharmacy the names of all holders of endorsements issued under this section.

* Sec. 3. AS 08.72.300(2) is amended to read:

(2) "optometry" is the examination [, OTHER THAN BY THE USE OF DRUGS,] 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 diagnosis and treatment, including the use of drugs, of inflammations, infections, and injuries of the anterior segment of the eyes and eyelids; [,] or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

* Sec. 4. AS 08.72.300(3) is amended to read:

(3) "practicing optometry" is an examination [, OTHER THAN BY THE USE OF DRUGS,] 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 diagnosis and treatment, including the use of drugs, of inflammations, infections and injuries of the anterior segment of the eyes and eyelids; [,] or the prescription or application 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;

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

(7) "legend drugs" means drugs whose containers must bear a label prohibiting dispensing without a prescription.

( ) "anterior segment" means that portion of the eye extending from the anterior surface of the cornea to the posterior end of the ciliary processes.

[illegible] without obtaining and filing an appropriate license is guilty of a misdemeanor and upon conviction is punishable by a fine of not less than $50 nor more than $100, or by imprisonment for not less than 10 days nor more than 90 days, or by both. Evidence that the defendant has failed to file a license with the clerk of the court is prima facie evidence that the defendant is not licensed. Each day of illegal practice is a separate offense.

	HESS CS SB 189	OPTOMETRIST CS SB 189
Board of Optometrists	Adds one board member who is a physician licensed in the state (Sec.1-2) Defines the public member as having no interest in the practice of optometry or medicine. (Sec. 2)	no change
Regulations	Gives the Board power to adopt regulations for the use of diagnostic drugs. (Sec. 3)	Gives the Board power to adopt regulations for the use of prescription drugs. (Sec.2 (d))
Powers and Duties	In conjunction with the State Medical Board, shall develop a list of specific diagnostic drugs and dosages to be used. (Sec.4(c)(3))	The Board shall furnish the Board of Pharmacy the names of licensed holders of endorsements (Sec.2(e)).
Continuing Education	The Board shall provide for C.E. for optometrists desiring to use drugs.	Drug use endorsement may be renewed upon evidence of completion of Continuing Education program specified and approved by Board. (Sec.2 (c))
Use of Drugs	A licensee must submit to the Board evidence of satisfactory completion of Educational requirements. (Sec. 8 (1)) Provides that the Board will develop and administer a test to licensees desiring to use diagnostic drugs. (Sec. 8)	A licensee must submit for the Board proof of a minimum of 100 transcript hours of Education, training, and clinical experience and passed a written examination. Training must be from an institution accredited by the Council in Postsecondary Accreditation or the US Department of Education or by an affiliated Institution. (Sec.2(a)) NOTE: Sec. 2 refers to endorsements issued under (b) but this subsection is missing from draft.

Definitions	Includes use of diagnostic drugs in the defintions of "optometry" and "practicing optometry". defines "diagnostic drug".	"legend drugs" drugs whose labels prohibit dispensation without a prescription. Deletes in "optometry" and "practicing optometry" other than by the use of drugs, and limits diagnosis and treatment to the anterior segment of the eyes and the eyelid. "anterior segment" is the portion extending from the anterior surface of the cornea to the posterior end of the ciliary process.
Grounds for Inposition of Disciplinary Sanctions	Use of "Dr." or "Doctor" with name without the word "optometry" (Sec. 7) Failure to fulfill educational requirements is cause for revocation of license validation (Sec. 8 (d))	Board may revoke or suspend a license endorsement for violations of regulations. (Sec. 2 (d))
Registration	Unlawful to practice optometry in the State beyond the scope of the license issued. (Sec. 5)	
Other	Requires referral to medical specialist on discovery of a pathological condition. (Sec. 6)	Establishes a classification list of legend drugs that optometrist may employ or prescribe (new Sec. 6)

SENATE HESS COMMITTEE OBSERVER/WITNESS SIGN-UP SHEET

DATE: ~~5/8/83~~ 5/16/83 SPONSOR: Josephson

SUBJECT(S): SB 189 - OPTOMETRY

NAME	REPRESENTING	ADDRESS	PHONE	Observer	Witness		
E.S. RABEAU	D H & S S	Pouch H-06	3090		X		
W TREAGER	COMMERCE	DIV. OCC LICENSING,	2534		X		

May 16, 1983

Joe, Peggy, Vic

Letter to Halford and P. Fisher
Talk w/ Milo re: Optometry

HB 270

Joe reviewed questions
discussed motion picture academy

SB 189

Dr Lahman - Dir, Public Health, DHSS
problems are minimal w/ CS

recommends

* pg 1, line 12 - keep Board at 5 members
to eliminate deadlock
reduce optometrists to 3 members
1 public member, 1 physician
should not have an even number

like line 31, pg 1 - medical board approval.
would force the boards to negotiate

pg 2, line 3-4 - examination - good.

* definition - except diagnostic drugs
administered in accordance
with AS

Harry Krueger, Dir Legislative Liaison
- minor fiscal impact
- term diagnostic should be kept

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		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	12

Key
E = In Emergency Use Only
x = Excludes Oral or Injectible Drugs

Source: American Optometric Association (1980)

April 13, 1983
SB 189
optometry

Joe, Vic, Rick, Peppy

Mike Fritz - House District 5

had practiced opthamology since 1936 until 1974. Practiced out of Ranch into rural areas.

no obj. to practicing medicine if licensed.

self-generated criteria.

"legend" drugs - (no pickering!) legend a noun and not an adjective.

definition of optometry is treatment of the eye without the use of drugs. Do purpose of legislation to do good for the public or the optometrists? No public demand.

"diagnosis and treatment" are in the purview of the practice of medicine and not optometry

many people w inflammation of the eyelid have trichanasis — and could not be identified w/o medical training. Many diseases & conditions are first exhibited through the eyes — medical background is necessary.

optometry as practiced is find and fulfills a need.

Joe do you oppose diagnostic drugs?

Yes, some diagnostic drugs cause very severe reactions in some people with various conditions. Training has improved but they still should not practice medicine beyond their competency.

Steve Dobson - John ~~Dewstay~~ Demoke — AK. Optometry Assoc.

support of bill

Demoke YK

James H Patterson - Opthalmologist

opposed to SB 189 - Ed. and background does not qualify to practice medicine. lack medical and clinical training. Tests available for use w/o drugs are sufficient

to provide services.

Dr. Harrison

Joe — What can an M.D. do to treat the eye?

Can use any drugs certified to use by narcotics administration.

Dr. Sam McKinkie - FBKS - ophthalmologist

10th yr. in a row that optometrists have attempted to pass such a bill.

No optometrist on Bd. has had any Clinical training in pharmacology. How can Board w/o training in medicine judge who should use what drugs.

Recent Court case awarded money paid by Fed. govt for Fed. optometrist not referring Child w/ problems who later lost an eye.

Joe — any studies from states which allow diagnostic drugs

findings by MD/lawyer that training is insufficient.

Harry Traugh - OL, Director

opposes the bill.

description of legend drugs too broad. 88 catgories of controlled substance in just Class I

Lacks positive protection.

Vic — testifying on behalf of whom

Dept of Com. & Econ. Develop. - Would need to get Dept numbers

Con 18 - recommend in consultation with state medical board.
took neutral position on last yrs. bill. (CS)

Joe fiscal impact?

Yes - license examiner for DEA info; registration purposes etc. would have to investigate school programs.

Dr Dave Spence - HHSS
Last session worked up compromise leg.
- diagnostic agents
- Collaborative sign off on drug use by Med. Board

Do not support.
- too broad of expansion into practice of medicine,
- adequacy of eye care in state should be addressed. Optometrists offer a lot but expansion into diagnostic or. Some topical antibiotics may be okay but full therapeutic use of drugs

Joe any other State laws as models?

Okla 3 allow use of therapeutic drugs
53 allow diagnostic use only.

Dr Harrison (thanks J) - opthalmologist
15 yr practice Eye disease specialist

Confusion in public in differences between optom / opthalmologists. Causes delays in treatment. Medication to dilate the

(4)

Eye - 99% of the examination can be done by physical treatment & history.

John Heineke

on Board.

Want licensed endorsement to include an examination for ~~surg~~ approval to use drugs

Challenge the 99% remark of Dr Harrison. Retinal detachments can not be seen without dilation.

Vic Were you not satisfied with Senate Hess Compromise language of last year.

Didn't see it.

MEMORANDUM

TO: JOE
FROM: NANCY
RE: TODAY'S MEETING

SB 189 - OPTOMETRY

THERE ARE TWO DRAFTS IN YOUR FILE, ONE FROM THE OPTOMETRISTS AND ONE THAT I DID FOR THE COMMITTEE WITH A CHART COMPARING THE TWO BILLS. IN SHORT:

THE HESS CS PROVIDES FOR USE OF ONLY DIAGNOSTIC DRUGS

THOSE WISHING TO USE DRUGS MUST PASS A BOARD TEST AND MAINTAIN THSIR COMPETENCT THROUGH CONTINUING EDUCATION.

THERE IS A MANDATORY REFERRAL TO MEDICAL SPECIALISTS IF A PATHOLOGICAL CONDITION EXISTS IN THE PATIENT.

ADDS A LICENSED PHYSICIAN TO THE BOARD, AND PROVIDES THAT A LIST OF ALLOWABLE DRUGS WILL BE ESTABLISHED WITH THE GUIDANCE OF THE STATE MEDICAL BOARD.

PROVIDES THAT AN OPTOMETRIST MAY NOT PRACTICE BEYOND THE SCOPE OF HIS/HER LICENSE.

NOTE: HARRY TRAEGER WILL BE HERE FROM OCCUPATIONAL LICENSING TO TESTIFY. THE ADDITION OF THE TEST WILL RAISE THE FISCAL NOTE.

OPTOMETRISTS CS:

PROVIDES FOR THE USE OF PRESCRIPTION DRUGS AND PROVIDES A TWO PAGE LIST OF ALLOWABLE DRUG CLASSIFICATIONS.

LICENSE BY ENDORSEMENT (NO TEST) AND BY EDUCATIONAL REQUIREMENTS.

REQUIRES CONTINUING EDUCATION.

CHANGES MEDICAL BOARD STATUTE TO ALLOW THE PRACTICE OF MEDICINE BY OPTOMETRISTS.

DELETES LANGUAGE IN DEFINITIONS PROHIBITING THE PRACTICE OF MEDICINE BY OPTOMETRISTS.

ALLOWS DRUG USE IN ONLY THE ANTERIOR PART OF THE EYE, AND DEFINES THE TERM.

NOTE: THE DRAFT IS SOMEWHAT DIFFICULT TO READ - THE LIST OF DRUGS IS ON PAGES 3-4 OF THE HANDOUT, THE DEFINTIONS ARE ATTACHED ON THE LAST PAGE.

ALSO SECTION 2 (b) IS NOT IN THE DRAFT, I THINK IT MUST HAVE BEEN INADVERTANT, IT IS THE PART DESCRIBING HOW THEY ARE ENDORSED TO USE DRUGS.

POSITION PAPER

HB 225

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

This bill is an example of the worst kind of special interest legislation. The purpose is not to make things better for the people of Alaska but to allow optometrists to practice medicine.

Up to this time the practice of medicine, which includes the writing of prescriptions and the use of drugs among which of course are eye drops, has been properly restricted by the will of the people, through the Medical Practice Act, to those who have graduated from a class A medical school who have received a M.D. degree and who have passed an examination or been licensed by a reciprocity to practice medicine in the state of Alaska.

By permitting optometrists to use drugs, one is in effect saying that, people who wish to practice medicine including the prescribing of drugs are so dumb that they have to fulfill the above mentioned qualifications to be M.D.'s or optometrists are so smart that they don't need to comply with the regulations of the Medical Practice Act.

Up to the present time optometrists have been able to employ their services for the good of Alaskans all over the state quite satisfactorily without invading the practice of medicine. Therefore, there is no reason at all for them to be using drugs as they wish to without complying with the regulations of the Medical Practice Act.

Optometrists go out into the bush and are able to extend the services for supplying eyeglasses and contact lenses to people in remote areas without the use of drugs. There is no reason why they should be allowed to practice medicine only because they wish to and not because it is going to do any good for the people in the remote areas.

In the Bethel area there are at least two optometrists who do itinerant optometry in the very small villages. When a problem arises, for which drugs might be necessary, the optometrists in question call the M.D. in charge of their activities back at the Bethel Hospital and are then permitted to use certain medications, under the direction of the M.D supervisor who ultimately is responsible for the good or bad result of what is done.

Allowing optometrists, after a crash course in diseases of the eye, to diagnose and treat disease is like allowing a two hundred hour light plane pilot to assume the command of a 747 jet. It also may be like letting a law clerk who has more or less specialized in one aspect of the law to practice law without passing the bar

examinations, graduating from law school, or obtaining a Bachelor of Law degree or one more advanced.

This bill attempts to do by legislation what optometrists should be required to do by education and licensure. Such a subversive effort to circumvent the Medical Practice Act should be thwarted by the overwhelming defeat of this piece of pernicious legislation.

There is no indication that anybody is doing without eyeglasses or contact lenses who requires them under the present system of care either by M.D.'s or by optometrists. Therefore, there is no reason why the sphere of optometrists should be increased by allowing them to practice medicine.

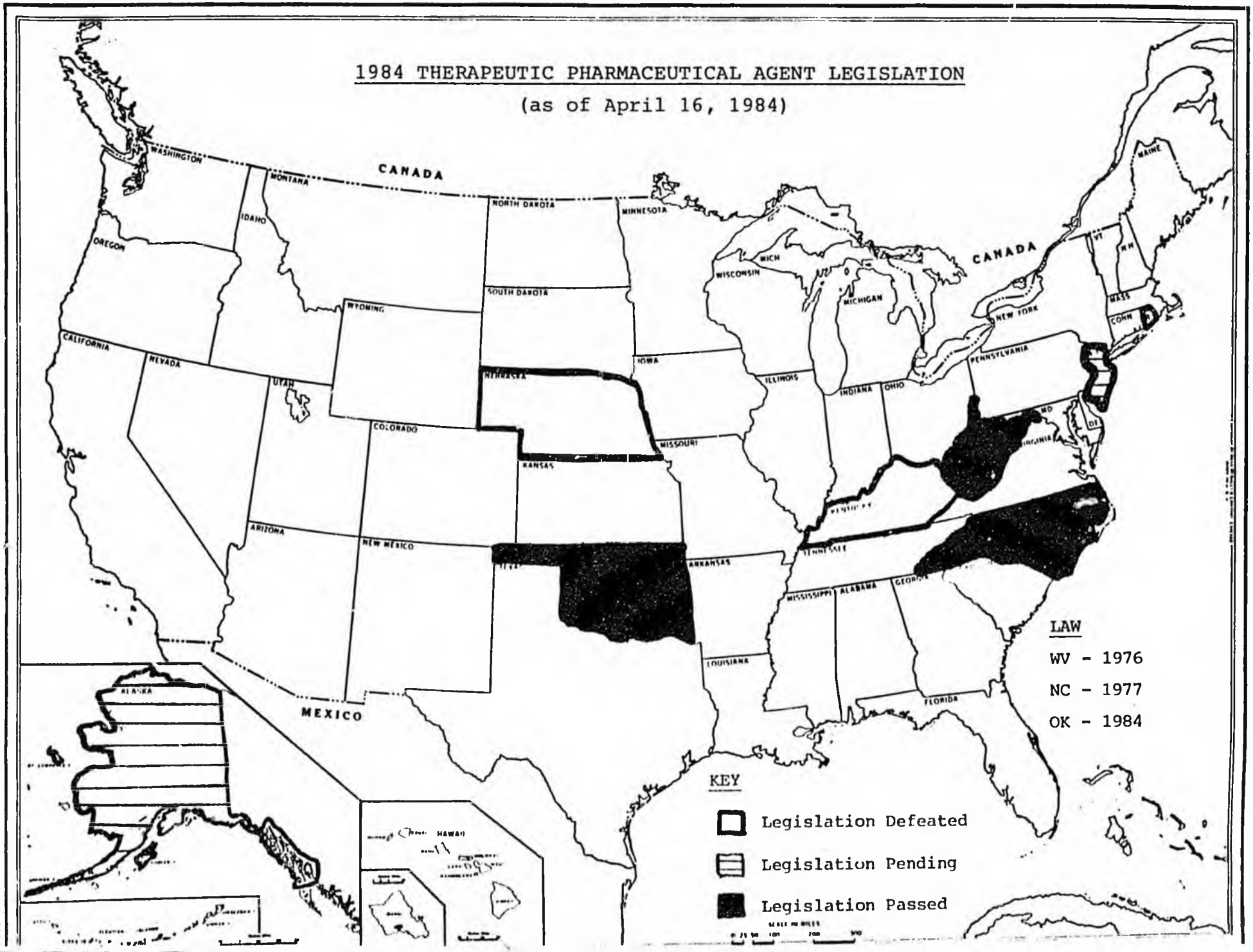
An examination of the bill allows the ignorance of optometrists regarding the practice of medicine to shine through. On page 5 lines 23 through 28 they speak of being denied the use of "of inflammations" which of course is a meaningless phrase since inflammations are not induced for the cure of any eye disease, although, this was once the case 40 years ago under certain circumstances.

In the list of drugs on page 4 lines 1 through 10, line 3 speaks of "anti-infectives", this of course is a meaningless hyphenated word and apparently refers to a drug that would combat infections. If these people not having been to medical school are not in a position to diagnose and treat disease it seems quite obvious that they are in no position to pick out proper drugs for infections, whatever their cause. Without understanding or being skilled in the use of bacterial sensitivity tests and other means of determing what an infectious agent might be it renders any use of anti-inflammatory drugs by optometrists completely meaningless and potentially dangerous.

The use of cycloplegics on line 7 and corticosteroids on line 6 demonstrates a complete ignorance of the dangers that these drugs represent, as do certain mydriatics line 10.

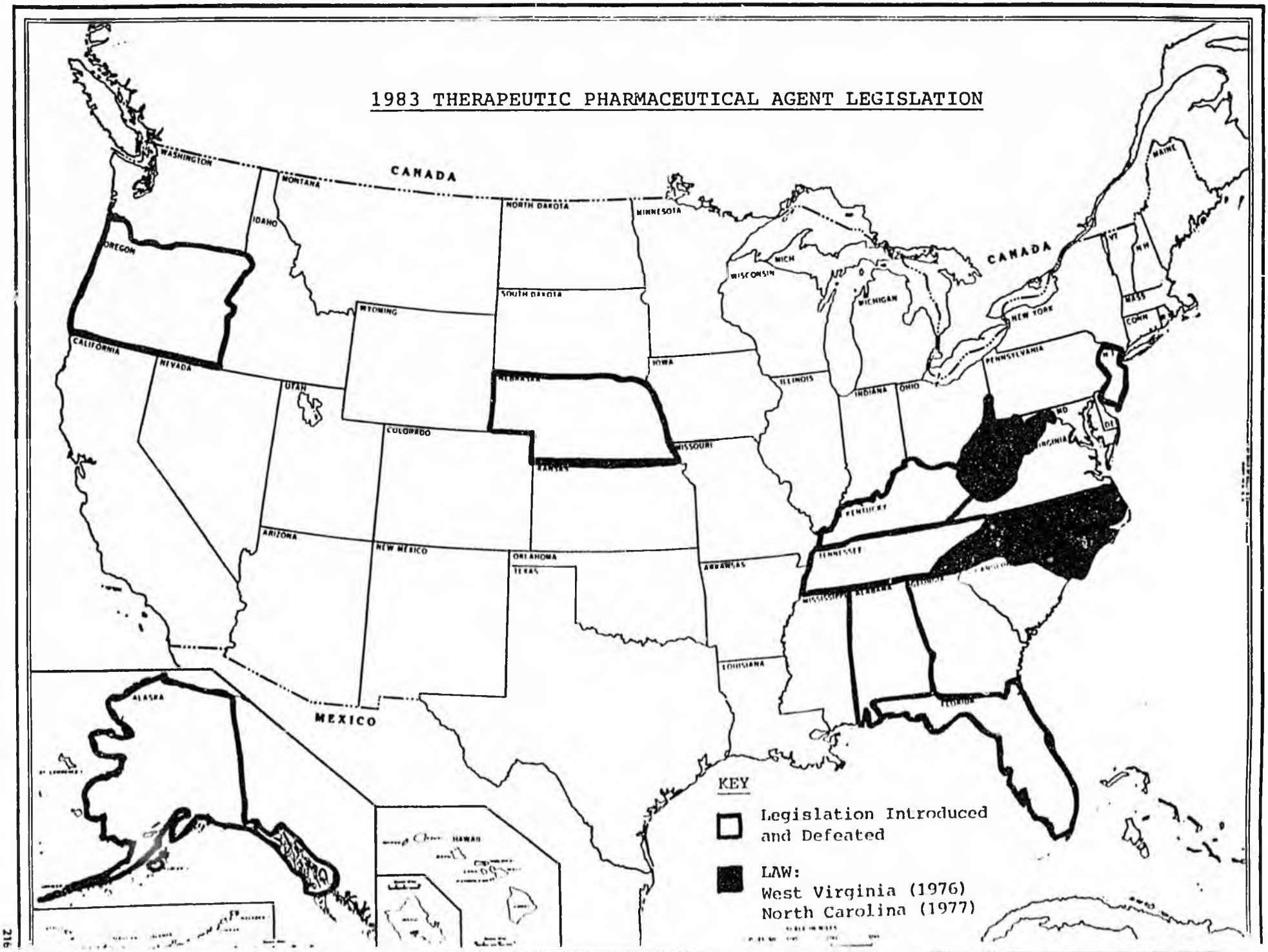
It is my feeling that this bill is completely against the public interest and should be roundly defeated.

Milo H. Fritz, M.D.



RAND McNALLY
STATE OUTLINE MAP
UNITED STATES
SIZE 8½ x 11

2167



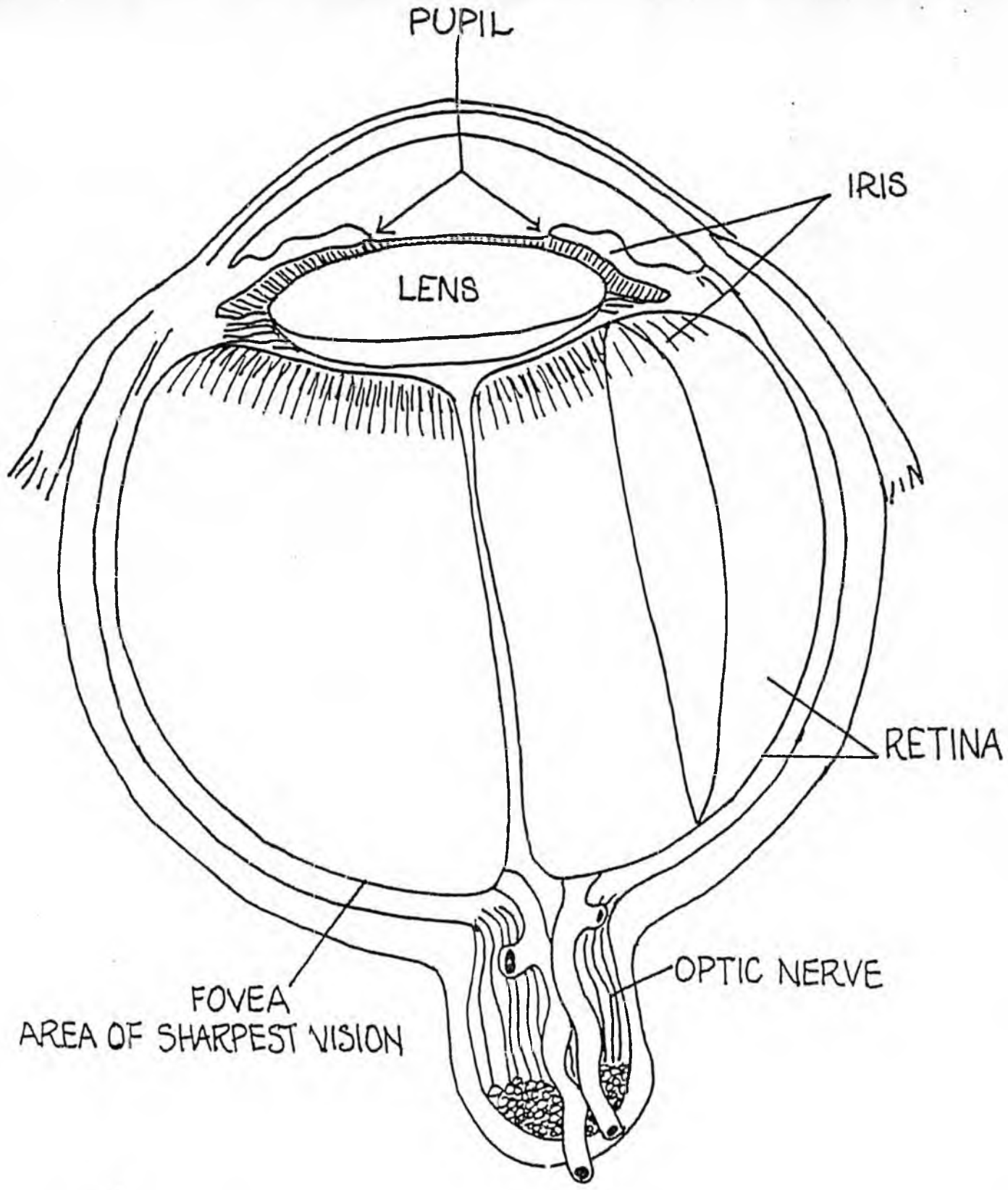
RAND McNALLY
STATE OUTLINE MAP
UNITED STATES
SIZE 8½ x 11

INVESTIGATIONS - OPTOMETRY

Fiscal Year	Allegation	Filed By	Location	Disposition
1981	Fee Dispute	Citizen	Ketchikan	No Violation No Jurisdiction Referred to Legal Counsel
1982	Expired License Cease & Desist	Investigative Section	Anchorage	Compliance Renewed License Removed from Board
1982	No Branch Office License	Investigative Section	Homer/ Anchorage	Compliance Licensed
1982	Unauthorized Dispensing of Drugs	Citizen	Bethel	Reprimand Compliance
1984	Window Display of Glasses Violation of 12 AAC 48.070(2) Unprofessional Conduct	Optometrist	Anchorage	Normal Window w/ View of Office Interior-Declined to Prosecute Regulation Violates Anti-Trust Laws
1984	Withholding Patient Records	Citizen	Anchorage	No Violation Patient Advised of Rights Under AS 18.23.065

BOARD OF EXAMINERS IN OPTOMETRY
EXAMINATION STATISTICS

EXAMINATION DATE	NUMBER OF APPLICANTS	PASSED	FAILED
JUNE 11, 1979			
Patient Exam	4	3	1
Pathology	4	3	1
Ophthalmic Optics	4	2	2
Oral Exam	4	4	0
JUNE 1980			
Patient Exam	9	9	0
Pathology	9	6	3
Ophthalmic Optics	9	6	3
Oral Examination	8	8	0
JUNE 1981			
Patient Exam	6	6	0
Pathology	7	5	2
Ophthalmic Optics	6	6	0
Oral Examination	6	6	0
JUNE 1982			
Patient Exam	3	3	0
Pathology	3	2	1
Ophthalmic Optics	3	3	0
Oral Examination	3	3	0
DECEMBER 1982			
Patient Exam	4	4	0
Pathology	4	3	1
Ophthalmic Optics	4	4	0
Oral Examination	4	4	0
JUNE 1983			
Patient Exam	6	5	1
Pathology	7	3	4
Ophthalmic Optics	6	6	0
Oral Examination	6	6	0
JANUARY 6, 1984			
Patient Exam	4	4	0
Pathology	6	5	1
Ophthalmic Optics	4	4	0
Oral Examination	4	4	0



THE HUMAN EYE

(Drawing compliments of
(Nancy Deitrick - 2/26/81
(Senate HESS Committee

DEFINITIONS

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

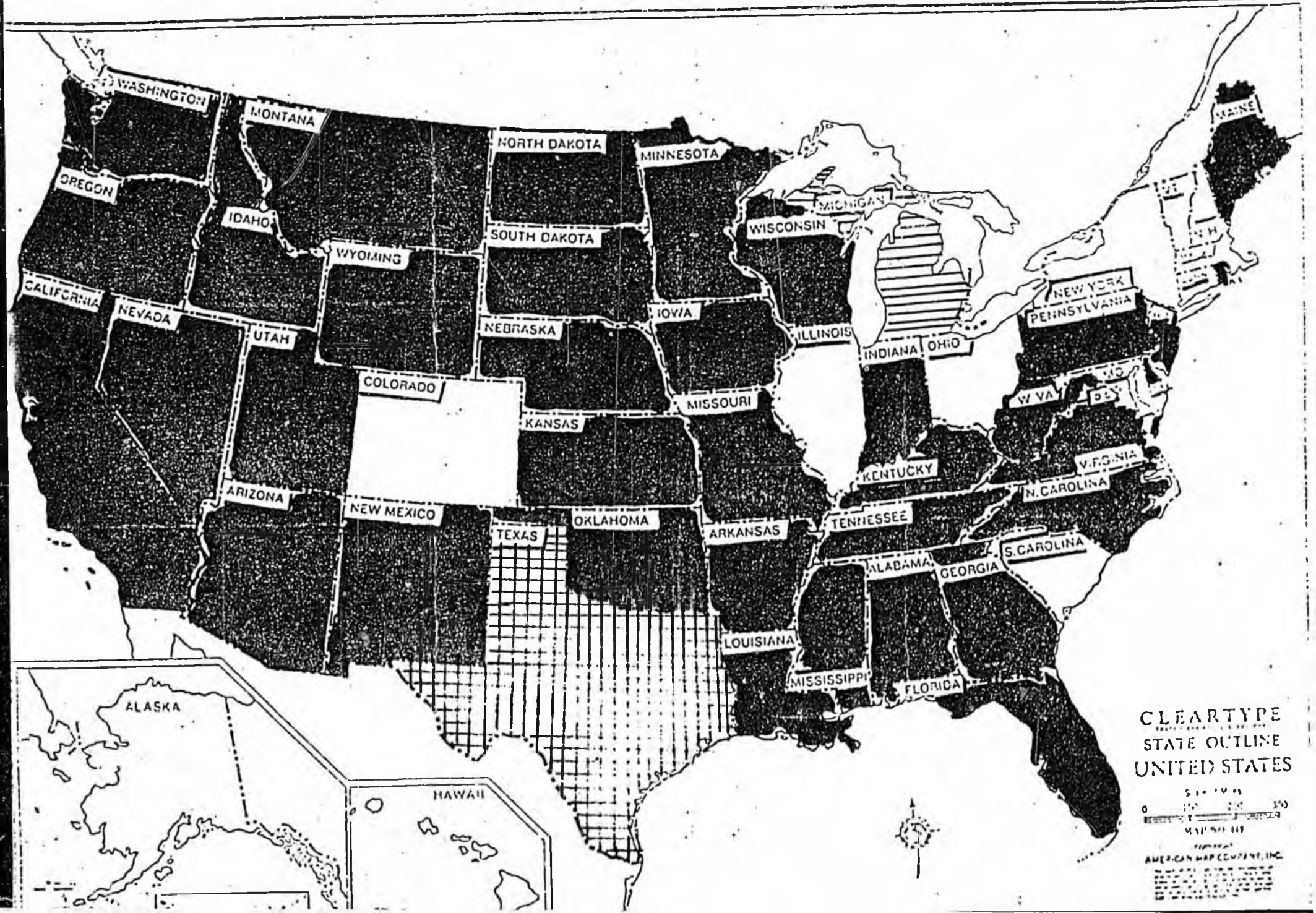
Corneal anesthetics - these temporarily remove corneal sensitivity to allow special viewing instruments to be placed in contact with the cornea.

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

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

UTILIZATION OF PHARMACEUTICAL .ENTS BY OPTOMETRISTS

February 25, 1983



SPECIFIC LEGISLATION: 32 States

The list (and dates of enactment) of the 32 states with current legislation specifically authorizing optometrists to utilize pharmaceutical agents is as follows:

STATE	DATE OF ENACTMENT
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975
Louisiana	July 6, 1975
Delaware	July 10, 1975
West Virginia*	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.)
North Carolina*	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979
Georgia	February 14, 1980
Arizona	April 25, 1980
Idaho	March 23, 1981
Oklahoma	April 6, 1981
Washington	April 23, 1981
Missouri	July 24, 1981
Minnesota	March 8, 1982
Mississippi	March 17, 1982
Virginia	February 25, 1983

*both diagnostic and therapeutic use

NOTE: None of these laws has ever been repealed. However, a July 30, 1982 opinion of the Texas state attorney general has rendered that state's unusual provision (an amendment to the medical practice act), which was enacted on August 5, 1981, inoperative.

GENERAL LEGISLATION: 4 states

There are four states which authorize the use of pharmaceutical agents by optometrists by extant general law or favorable attorney general opinion:

Alabama	(diagnostic use)
Florida	(diagnostic and therapeutic use)
Indiana	(diagnostic use)
New Jersey	(diagnostic use)

NOTE: In addition, in Michigan, while there is no statutory prohibition of the use of pharmaceutical agents by optometrists, there is a negative opinion of the state attorney general.

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

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		XE	
Louisiana	X							X
Maine	X			X	X			
Minnesota	X							X
Montana	X		X	X	X	X	XE	
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	XE	
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	Xx	Xx						X
Wisconsin	X		X	X	X	X	XE	
Wyoming	X		X	X	X	X	XE	
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)

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

Telephone (907) 283-7575

March 16, 1983

Joe Josephson
Pouch V
Juneau, Alaska 99811

Dear Mr. Josephson;

I am writing you to voice my endorsement of the Optometric Drug Bill and to enumerate some facts concerning Optometric and Ophthalmology as it is practiced in Alaska.

Optomectrists give the state much larger coverage than does Ophthalmology. The Kenai has two Optometrists and two Ophthalmologists. As you well know, 50% of the Kenai's Ophthalmologists now practice in Juneau. The other Ophthalmologist practices 3 day per week in Soldotna, one day per week in Anchorage and one day per month in Seward.

My partner and I both practice 4 days per week in Kenai. My partner travels 1 day every two weeks to Homer and I travel 1 day every 3 weeks to Seward and 1 day per month to Seldovia. The larger bulk of the Vision Care given on the Kenai Peninsula is delivered by Optometry, this holds true for the entire state.

Optometric credentials far outweigh those of the General Practioner concerning eye care! Every graduate of an Optometric School has an undergraduate degree, BS or BA plus 4 years studying the eye adnexa, its care and conservation!

Ophthalmologists contrary to their ballyhood claims, are in reality not as well trained in many aspects of eye care as are Optometrists.

Optometrists are as well trained as Dentists and Podiatrists and should be allowed to ulitize their training!

If medicine had a jurisprudence specialty you as well as all other non-medical members, of the legislature would be considered and presented by organized medicine as lacking.

Some Alaskan Optometrists are presently using every drug considered in this bill daily. This occurs in the military as well as the public sector. Many of the drugs which would be covered by this bill are available without prescription to the general public.

To paraphase Milo Fritz, M.D., who has been a vocal opponent of this bill in the past, "If you want to use drugs, go to Medical School." To me this translates, "Don't compete against medicine."

In summing up I would like to make these points:

1) Where needed, drugs help you give a much better examination.

2) Many of these drugs are presently available without prescrition to the general public.

3) Optometrists are qualified to use the drugs which would be covered by the Optometric Drug Bill.

4) When enacted the Optometric Drug Bill will save Alaskans a lot of money.

5) The jury is already in! The enclosed map shows where Optometrists are allowed to use durgs. Many of these states have allowed Optometric drug use for years with positive results.

I would appreciate your support of this bill. If I can be of any further help please feel free to contact ne.

Sincerely;

Robert D. O'Connell, O.D.

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

ANCHORAGE EYE AND CONTACT LENS CENTER
1345 W. NINTH AVE. PHONE: (907) 272-2557
ANCHORAGE, ALASKA 99501

March 7, 1983

Honorable Joe Josephson
Pouch V
Juneau, Alaska 99811

Dear Joe,

We talked earlier this year about Optometry and the use of drugs. Please support House Bill 225 , when it reaches the senate.

Optometry is trained and can regulate itself with respect to drug usage. The M.D.'s should regulate M.D.'s and Optometry should regulate Optometry. I feel frustrated not being able to use the full extent of my training.

Incidently, I am licensed in Washington and Oregon where I can use drugs in my practice.

Respectfully,

Jim Falconer

Jim Falconer, O.D.

3/31/83.

Roger F. Spach
1201 Denali ST, #311
Anchorage, AK 99501

Sen. Joe Josephson
Senate Hess Comm.
Pouch V
Juneau, AK 99811

Senator Joe Josephson

I strongly urge you to support House Bill 225 Allowing use of Drugs by OPTOMETRISTS. This will help lower Cost to Senior Citizens for Eye Care.

I am a 60 years resident + my wife is a 30 year resident of Alaska. We would appreciate your support.

Thank You.

Roger F. Spach
Louise G. Spach

John W. Page II O.D.
4050 Lake Otis Suite 103
Anchorage, Alaska 99504

April 8, 1983

Senator Joe Josephson
Chairman Senate HESS Committe
Pouch V
Juneau, Alaska 99801

Dear Chairman,

I strongly urge you to support House bill 225, which would allow Doctors of Optometry to use Ophthalmic drugs in their Professional practice.

Thank you for your thoughtful consideration.

Cordially,

John W. Page II O.D.

JWP/cp
c/c Dr. Phillip W. Bach