

ALASKA LEGISLATURE COMMITTEE FILES | 1983- | 1984 86 / 2

2341 SHESS • SB 189

RECEIVED

APR 13 1983

Josephson

4.6.83
WAYNE HOWE
1021 W. 12TH
ANCHORAGE, AK
99501

SENATOR JOSEPHSON;

I URGE YOUR SUPPORT OF THE
OPTOMETRIST'S DRUG BILL. IT WILL BE
REALLY HELPFUL IN AREAS WITHOUT SPECIALISTS,
WHERE THE GENERAL PRACTICE DOCTOR MUST
PROVIDE TREATMENT WITH FAR LESS EYE
TRAINING THAN THE OPTOMETRIST. WE
NEED BETTER AVAILABILITY OF EYE CARE
IN ALASKA.

Thank You
Wayne Howe

SITKA VISION CLINIC
T. B. McLAUGHLIN, O.D., P.C.
BOX 498
SITKA, ALASKA 99835
TELEPHONE 747-6644

April 8, 1983

Senator Joe Josephson
Chairman HESS
Pouch V
Juneau, Alaska

RECEIVED

APR 12 1983

Josephson,

Dear Senator Josephson;

I strongly urge your support for the bill relating to the practice of optometry, authorizing the use of drugs.

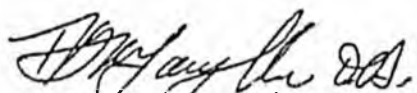
For the past ten years I have been the only resident eye care practitioner in Sitka. Presently an ophthalmologist visits Sitka, for 3-4 days, 2-3 times a year. This makes me the only specialized eye care provider for 11½ months a year, for a population of approximately 8,000 people.

I have always been proud to practice in the state where I was born and have resided for 35 years. Now I am finding myself having to cope with out-dated legislative restrictions which limit the effectiveness of my practice. Although I have received hours of training in the use of pharmaceuticals, which would allow me to be licensed to use them in all but a few states, I am unable to put this to use for the benefit of my patients.

Those Sitkans that do require treatment must travel to Seattle or Juneau, or be treated with little or no diagnostic work-up, by the general practitioner who has little specialized ocular training and none of the specialized instrumentation which I have in my office. This situation results in expensive and often inappropriate care.

Allowing optometrists to fully utilize their extensive training would be of great benefit to all Alaskans. Thank you for your support.

Sincerely,


T.B. McLaughlin, O.D.

TBM/dd

[RECEIVED]

APR 12 1983

SRA Box 1026-B
Anchorage, Alaska 99502
April 7, 1983

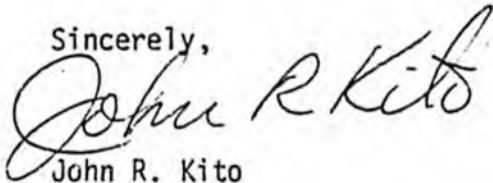
Josephson,

Senator Joe Josephson
Chairman, Senate HESS Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

Please support HB 225/SB 189 allowing use of ophthalmic drugs by optometrists. This legislation is in the best interest of the people of Alaska in saving money and time, especially for "bush" residents.

Sincerely,

A handwritten signature in cursive script that reads "John R. Kito". The signature is written in dark ink and is positioned above the printed name.

John R. Kito

Senator Joe Josephson
Chairman HESS
Pouch V
Gineau, AK

April 8, 1983

Dear Senator Josephson:

I am writing to ask you for your support on allowing optometrists to use drugs. I feel this greatly benefit the residents of Sitka and all Alaska.

Thanking you in advance for your help.

Sincerely,
Karen S. Bueyka

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APR 13 1983

Josephson

April 8, 83

Dear Senator Josephson,

I strongly urge you to support the optometry drug bill. As a concerned citizen, I feel if this bill is passed, our family optometrist could serve us more efficiently.

Thank-you.

Mr + Mrs Joseph Mack
331 Lionheart Ct.
Anchorage, Ak. 99504

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APR 13 1983

Josephson

RECEIVED

APR 13 1983

Joe Josephson
Senator
Pouch V
Juneau, Alaska 99811

~~Josephson~~

April 7, 1983

Dear Senator Josephson;

I am a Physicians' Assistant practicing in Alaska and am writing to you to voice my support of ~~SB 189~~ *SB 189*.

I have been a Physicians' Assistant for four years and have worked in states that have legislature allowing Optometrists to use pharmaceuticals in the diagnosis and treatment of eye disorders. I frequently refer patients to them and have been pleased with the quality of care and have had positive feedback from those patients.

I have found that the limitations placed on them by not allowing them to use pharmaceuticals in their practice a handicap.

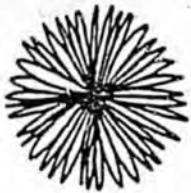
I hope that when this bill comes before you that you will support it.

Thank you very much for your consideration in this matter.

Respectfully,

Barry L. Campbell

Barry L. Campbell PA-C



PROFESSIONAL BUILDING COMPANY, INC.
529 SIXTH AVENUE • 907-452-6334 • FAIRBANKS, ALASKA 99701

April 7, 1983

RECEIVED

APR 13 1983

Senator Joe Josephson
Pouch V
Juneau, Alaska 99811

Josephson,

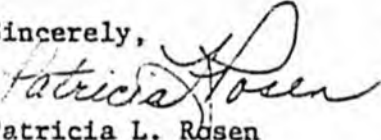
Dear Senator Josephson;

I would like offer support for passage of SB 189.

For many years our company has rented space to physicians, dentists and optometrists and I am familiar with their educational backgrounds. There is a great deal of it that is the same and in many instances in the same classes at the same colleges or universities.

It seems strange that with the similarities in background and training that dentists can use and prescribe many drugs while optometrists are prohibited from using any at all.

Sincerely,


Patricia L. Rosen
Manager

PLEASE REPLY BY AIRMAIL

DR. CURTIS M. JOHNSON
OPTOMETRIST
330 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701
Telephone 456-4010

RECEIVED

April 7, 1983

13 1983

Senator Joe Josephson
Pouch V
Juneau, Alaska 99811

Josephson,

Dear Senator Josephson;

I am writing to urge support and passage of SB 189, a bill related to the use of drugs by optometrists.

Legislation similar to this has been before both houses in past sessions but the medical lobby has been successful in keeping it from the floor.

I am sure you have heard many arguments on both sides of the issue and will not bore you with a re-run, I would just like to point out a couple of things I think are significant.

Legislation similar to SB 189 are now law in 35 other States, some relatively new and many of long years standing so this is nothing new. Several studies have been done and there is not one documented case of eye injury or damage caused by the use of drugs by optometrists, indeed the results have all been positive in the area of more informed and timely referrals.

Another interesting point is that malpractice insurance, which is very expensive for physicians, is relatively inexpensive for optometrists and the insurance companies charge the same premiums whether drug usage is allowed or not. Also our premiums have remained stable for many years.

Thank you for your help in this matter.

Sincerely,


Curtis M. Johnson, O.D.

RECEIVED

APR 13 1983

Josephson,

April 4, 1983

The Honorable Joseph Josephson
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

I would like to offer my support for HB 225 and SB 189 which would permit appropriately trained and licensed optometrists to use prescription ophthalmic drugs for diagnosis and treatment of eye problems.

I work closely with two optometrists in Bethel, John Demske, O.D., and James Taylor, O.D., who are authorized under standing orders approved by the medical staff of the Yukon Kuskokwim Delta Regional Hospital* to use certain prescription drugs for the diagnosis and treatment of eye disorders. They also work under the indirect and direct supervision of the Ophthalmology Department at the Alaska Native Medical Center in Anchorage. John Demske has been operating under these standing orders for almost five years without mishap. Both optometrists have made a substantial contribution to the increased quality of eye care in this region. The physician staff respects their knowledge and expertise and regularly consults them regarding eye problems.

The Ophthalmology Department at the Alaska Native Medical Center has recommended that the eye care program operating in this region be considered as a model for other Service Units in the Alaska Area Indian Health Service. This recommendation has been supported by the Service Unit Directors and Clinical Directors of the Alaska Area.

The backbone of the health care system in rural Alaska has been trained paramedical personnel, including Physician Assistants, Nurse Practitioners, Public Health Nurses, Community Health Aides, and in this area, the Optometrists with the YKHC Eye Care Program. They have proved themselves vital in achieving otherwise unobtainably high standards of health care in remote areas. The professional performance of the optometrists in this region has been excellent. They have provided quality eye care services otherwise unavailable to the people of the Delta. They have recognized their limitations and always referred patients when appropriate.

Based on my experience with optometrists using prescription ophthalmic medications for specified diagnostic and therapeutic purposes in this area I am inclined to agree that the major obstacle to a more extensive utilization of the optometrists' special skills and knowledge is a financial one rather than a primary concern for the quality of eye care available to the people of the state.

I strongly endorse SB189 and HB 225. If I can be of any further help, please let me know.

Sincerely,

Bill Searman MD

RECEIVED

APR 13 1983

DANIEL H. FARRAR, D.D.S.

BOX 543

KODIAK, ALASKA 99615

TELEPHONE 486-3257

Josephson,

4-8-83

Senator Joe Josephson
Chairman - Senate Health, Education + Social Services
Pouch V
Juneau, AK 99811

Dear Senator:

I would like to speak in favor of Senate Bill 189 allowing the topical application of various medications by optometrists.

The benefits to the public would be significant both in cost and convenience. By passing this bill you would allow optometrists to extend both their diagnostic and treatment services in areas of practice in which they are highly trained.

Thank you for your consideration.

Sincerely,

Dan Farrar, D.D.S.

KNOX N. CHRISTIE, D.D.S.

RECEIVED

APR 13 1983

April 7, 1983

Josephson,

Senator Joe Josephson
Chairman, Senate Health, Education & Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

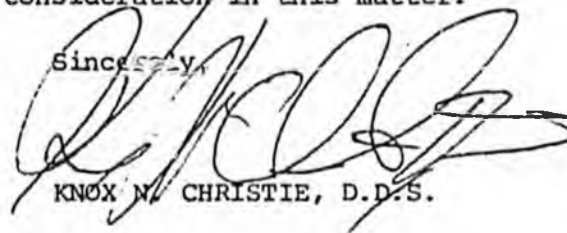
RE: Senate Bill #189, Optometric Therapeutic
Bill:

I am in favor of Senate Bill #189. Some regulation and certification relating to sufficient training in the area of topical therapeutic use should be addressed, and control administered by the state licensing board.

I believe that topical therapeutics use by optometrists would be valuable to their patients. If the competence of the administering optometrist is properly controlled, the bill would benefit the public health and the quality of the care the public receives would be enhanced.

Thank you for your consideration in this matter.

Sincerely,



KNOX N. CHRISTIE, D.D.S.

NORTH PACIFIC MEDICAL CENTER

P. O. BOX 248
KODIAK, AK 99615

TELEPHONE (907) 486-4183

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

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

April 7, 1983

RECEIVED

APR 13 1983

Senator Joe Josephson
Chairman Senate Health, Education
and Social Services

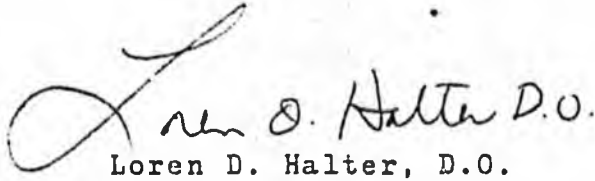
Josephson,

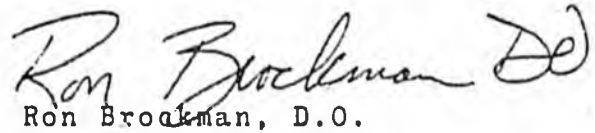
Pouch V
Juneau, Ak 99811

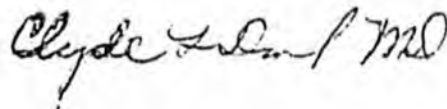
RE: Bill #189

Dear Sir:

We the undersigned support Bill #189, Optometric Therapeutics.


Loren D. Halter, D.O.

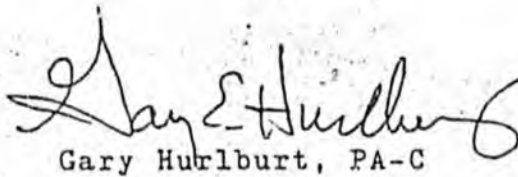

Ron Brockman, D.O.

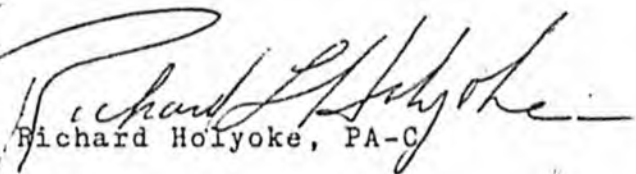


Clyde Deal, M.D



Kevin Creelman, M.D.


Gary Hurlburt, PA-C


Richard Holyoke, PA-C

April 9, 1983

Senator Joe Jorjenson
Chairman, Health, Education
and Social Services
Alaska State Senate
Couch V
Bureau, Alaska 99811

RECEIVED

APR 17 1983

Dear Senator Jorjenson:

I wish to offer My Support for Senat. Bill 189 and
urge that you do likewise. I know that optometrists
are more than qualified to decide when to treat
and when NOT to, prudely referring those patients
It makes no sense to me to give ophthalmologists
exclusive right to treat minor eye infection
and charge high fees when they can already
make more money in one day of surgery than
most working people make in a month.

Please support this bill. Thank you.

Very truly yours

Mrs. Michael Brandenburger

Box 216 Chickagoof Loop

Eagle River, Alaska
99577

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

IDENT

Dennis A. Swarner, O.D.
Drawer 4370
Kenai, Alaska 99611
April 8, 1983

RECEIVED

APR 13 1983

Joe Josephson
Pouch V
Juneau, Alaska 99811

Josephson

Dear Mr. Josephson;

I am writing to ask your support for Senate Bill #189, an act relating to the practice of Optometry.

This bill would allow Optometrists to dispense drugs, as regulated by the Board of Optometry. This would put Optometrists on the same level as dentists and podiatrists as concerns the use of drugs in Alaska. The education of a Doctor of Optometry is similar to that of a dentist and podiatrist, with a background in the basic sciences and medical training.

Most of the Alaskan Optometrists have recently taken a transcript quality course in ocular therapeutics, and would like to be able to use these skills, that, if not used will deteriorate. It is in the interest of our patients and our profession that we be able to maintain the highest standards of training and practice.

Optometrists are located in more cities and towns than are Ophthalmologists. The passage of this bill that is before your committee would allow an Optometrist to provide care to a patient with an acute problem, saving that patient both time and money necessary to travel to see an Ophthalmologist.

As President of the Alaska Optometric Association, I would like to thank you for considering this bill.

Regards;



Dennis A. Swarner, O.D.

April 8, 1983

Dear Senator Josephson:

I strongly urge you to support the optometry drug bill. I feel that this will better enable my optometrist to serve the needs of my family.

Thank you,

Sara Castle

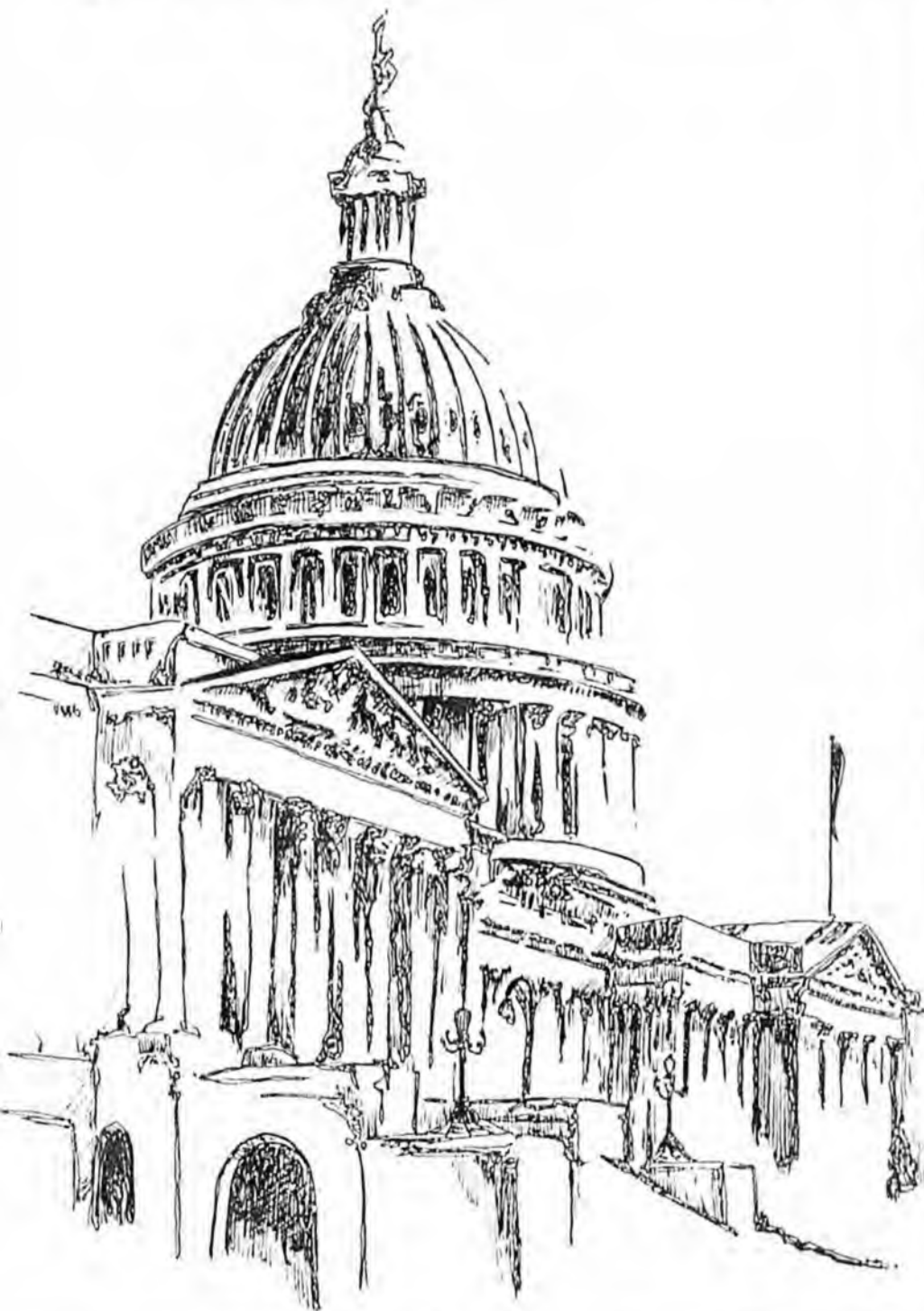
Sara Castle,

RECEIVED

APR 13 1983

Josephson,

OPHTHALMOLOGY'S VOICE IN GOVERNMENT RELATIONS



The person who says
that he is above politics
is really saying that
democracy is beneath him.

Overview

The Governmental Relations Secretariat and the Office of Governmental Relations form the American Academy of Ophthalmology's coordinating link, clearinghouse and action arm for most contacts with the federal government.

Working closely and cooperatively, these offices afford the Academy a unified approach to influence regulatory policy and affect legislation bearing on ophthalmology.

The Governmental Relations Secretariat is composed of Academy-member M.D.'s across the country: a Secretary, Robert D. Reinecke, M.D., who serves on the Academy Board, five associate secretaries and their active committees.

Associate secretaries meet quarterly with the Secretary and present their studied recommendations, which the Secretary takes to the Board for approval.

The Office of Governmental Relations, a staff of non-physicians in Washington, D.C., works to transmit the Academy's policies and opinions across to the legislative and the executive branches of government.

Toward this end, its staff monitors legislative developments in the U.S. House and Senate that may affect eye care or its providers. Similarly it tracks regulatory issues throughout departments and agencies of the bureaucracy.

The staff thus maintains contact with Senators and Representatives, Congressional committees, federal agencies, and their various staffs.

In these ways, the Office of Governmental Relations serves as an effective liaison between Academy members, the Congress, and federal government agencies.

It also assists ophthalmologists who come to Washington to testify at Congressional hearings or to contact their Senator or Representative about an issue or piece of legislation vital to eye care. It closely coordinates the Key M.D. program and the parallel Congressional Correspondent effort.

Governmental Relations Committee

Secretary

Robert D. Reinecke, M.D. Philadelphia, PA

Associate Secretaries

James V. Aquavella, M.D. Rochester, NY
Thomas A. Frey, M.D. Falls Church, VA
Michael A. Lemp, M.D. Washington, DC
Richard S. Ruiz, M.D. Houston, TX
Hunter R. Stokes, M.D. Florence, SC

Whitney G. Sampson, M.D.,
Consultant
Houston, TX

Charles B. Sonneborn
Director

Governmental Relations Committee takes a photo break during a recent meeting in Washington, D.C. Seated (L to R) Richard S. Ruiz, MD; Bruce E. Spivey, MD, Academy Executive Vice President; Robert D. Reinecke, MD, Secretary, Governmental Relations Committee; James V. Aquavella, MD. Standing (L to R) Whitney G. Sampson, MD, Academy President-elect; Hunter R. Stokes, MD; and Thomas A. Frey, MD. Not shown: Michael A. Lemp, MD.



Committee for Research and Regulatory Agencies

One of the charges to this Committee is to keep the Academy apprised of eye care issues originating in the federal regulatory agencies, such as the Food and Drug Administration (FDA), the Federal Trade Commission (FTC) and the National Eye Institute (NEI) and to furnish a commentary to the Board.

With the FDA, for example, the group supports voluntary device standards, monitors issues before the ophthalmic device panel, and provides input on a variety of drug and device related issues. At present a number of FTC issues emanating from the pending Eyeglasses II rule are being tracked.

One of the Committee's most important tasks is to formulate and organize a coordinated approach to generate Congressional support of eye research, stewarded by the National Eye Institute.

It also recommends Academy members for appointment to various federal advisory committees whose work involves ophthalmology.

Associate Secretary

Michael A. Lemp, M.D. Washington, DC

Committee Members

H. Dwight Cavanagh, M.D.	Atlanta, GA
John W. Chandler, M.D.	Seattle, WA
Oliver H. Dabezies, Jr., M.D.	New Orleans, LA
James H. Elliott, M.D.	Nashville, TN
Arthur H. Keeney, M.D.	Louisville, KY
Walter J. Stark, M.D.	Baltimore, MD
Louis A. Wilson, M.D.	Atlanta, GA

Committee for Federal Legislation

This Committee studies federal legislation pertaining to ophthalmologists and eye care as the legislation is being created, proposed and considered.

It keeps the leadership of the Academy informed, analyzing the legislation and recommending Academy policy to the Secretariat and the Board.

The Committee also initiates legislation on behalf of the Academy and recommends the proposed legislation to federal representatives.

It calls on Congressional offices regularly, and identifies issues for the Key M.D.'s and Congressional Correspondents.

In addition, the Committee, whose membership is from the Washington Metropolitan area, is charged with contacting federal officials. It provides liaison between the Academy and governmental agencies - such as the Department of Health and Human Services and the Congress.

Associate Secretary

Thomas A. Frey, M.D. Falls Church, VA

Committee Members

David T. Casey, M.D.	Washington, DC
Richard A. Falls, M.D.	Vienna, VA
Allan D. Jensen, M.D.	Baltimore, MD
John F. Nowell, M.D.	Arlington, VA
Marshall M. Parks, M.D.	Washington, DC
A. Raymond Pilkerton, M.D.	Washington, DC
William L. Rich III, M.D.	Falls Church, VA

Committee for Health Manpower and Planning

This Committee's most enduring achievements involved preparation of the Academy's series of monographs dealing with health manpower: Ophthalmology (Eye Physician and Surgeon) Manpower Studies for the United States. The five-part series includes:

- Part I: Eye Disease Estimates, Time Requirements for Eye Disease Diagnosis, Treatment, Refractions, and Preventive Eye Care.
- Part II: Demand for Eye Care: A Public Opinion Poll Based Upon a Gallup Poll Survey.
- Part III: A Survey of Ophthalmologists' Viewpoints and Practice Characteristics.
- Part IV: Ophthalmology Manpower Distribution
- Part V: Summary and Conclusions*

* Part V should be available in early 1984. Upon completion of this charge and pending a renewed interest in Graduate Medical Education, the Committee will become inactive in 1984.

Associate Secretary

Richard S. Ruiz, M.D. Houston, TX

Committee Members

Frederick T. Fraunfelder, M.D.	Portland, OR
James P. Ganley, M.D.	Shreveport, LA
George L. Spaeth, M.D.	Philadelphia, PA
Theodore Steinberg, M.D.	Fresno, CA
Jonathan D. Trobe, M.D.	Gainesville, FL

Committee for State Affairs

As the name implies, this Committee keeps an eye on legislative affairs that affect ophthalmology in the 50 states.

Furthermore, it establishes a network between the 50 states, and between the states and the Academy, so that there is constant, up-to-date communication about the issues and concerns involving ophthalmology.

This Committee analyzes major bills that are introduced in state legislatures and likely to affect ophthalmology. It seeks to identify legislative trends and uses its clearinghouse function to alert states of such trends and related strategies. This Committee sponsors an annual conference for legislative advocates and lobbyists of state ophthalmological societies.

Planning is underway to forge a definitive working linkage between the Committee and the AAO Board of Councillors.

Associate Secretary

Hunter R. Stokes, M.D. Florence, SC

Committee Members

William C. Frayer, M.D.	Philadelphia, PA
Carl Garfinkle, M.D.	Arlington Heights, IL
Douglas A. Liddicoat, M.D.	Watson, CA
Thomas F. Moore, M.D.	Phoenix, AZ
David W. Parke, M.D.	Meriden, CT
Philip A. Shelton, M.D.	West Hartford, CT
Reginald J. Stambaugh, M.D.	West Palm Beach, FL

Committee for Health Plans

Issues affecting the financing and delivery of eye care through health plans are studied and monitored by this Committee.

The Committee for Health Plans examines and evaluates new developments and proposed vision care plans – private and governmental – analyzes each and recommends Academy policy and initiatives.

It also monitors existing programs within the Health Care Financing Administration – Medicare and Medicaid, for example, and the Public Health Service's HMO initiative, and the Department of Defense (CHAMPUS), and proposals for any federalized health insurance.

The Committee acts on reimbursement initiatives, drafting issue papers and policy statements as appropriate, for consideration by the AOA Board.

Current issues such as prospective payment by diagnostic related groupings (DRGs), preferred provider organizations (PPOs) and physician assignment are being closely monitored and addressed.

Associate Secretary

James V. Aquavella, M.D. Rochester, NY

Committee Members

S. Arthur Boruchoff, M.D. Boston, MA

Robert J. Crossen, M.D. Ann Arbor, MI

Barton L. Hodes, M.D. Hershey, PA

David J. McIntyre, M.D. Bellevue, WA

Lawrence A. Winograd, M.D. Denver, CO

Ira G. Wong, M.D. San Mateo, CA

Charles E. Jaeckle, M.D., Defiance, OH

Consultant

The Key M.D. Program

There are more than 100 U.S. Senators and Representatives who, by virtue of their committee assignments, have been designated by the Office of Governmental Relations as "key" to ophthalmology.

Key M.D.'s volunteer to keep in touch with their congressional representatives on these essential committees and to voice Academy opinions when legislation affecting ophthalmology is being considered.

They do this by writing letters to their representatives, by visiting them in their state or district offices, and by coming to Washington each spring to call on them in their Capitol Hill offices.

Key M.D.'s usually know their representatives on a first name basis. They often know the representative socially or as a patient. Ideally, the Key M.D.'s work on their representative's election campaign and make financial contributions, as well.

The Committee for Federal Legislation keeps the Key M.D.'s informed on issues and legislation of importance to ophthalmology.

A listing of these key ophthalmologists is maintained in the Office of Governmental Relations.

Congressional Correspondents

Congressional Correspondents are M.D.'s who agree to contact their representatives on legislative issues involving ophthalmology by phone, letter, or telegram.

Their representative usually holds a committee assignment less vital to ophthalmology than those of the Key M.D.'s. Nevertheless all U.S. Congressmen are important enough to be monitored and contacted.

The Office of Governmental Relations alerts Congressional Correspondents to the need to contact their representative and keeps them informed on pending legislation and related issues.

Rep. Howard C. Nielson (R-U) discusses a point at Congressional Reception held in conjunction with the 1983 Key MD program in Washington. (L to R) Robert A. Rubenstein, MD; Tom Donnelly, Special Assistant to the President for Congressional Liaison; Edward N. Brandt, MD, Assistant Secretary for Health, Dept. of Health and Human Services; Rep. Nielson; and Robert D. Reinecke, MD, Secretary, Governmental Relations Committee of AAO.





Office of Governmental Relations

Suite 300

1101 Vermont Ave., N.W.
Washington, D.C. 20005-3570

(202) 737-6662



AMERICAN ACADEMY OF OPHTHALMOLOGY

OFFICE OF STATE AND
SUBSPECIALTY RELATIONS

May 9, 1984

JOHN D. LEE
Director

HENRY L.D. EBERT
Assistant Director

Nancy Dietrick
Senator Joe P. Josephson
Pouch V
Juneau, AK 99811

Dear Nancy:

Although we've spoken several times recently, I want to take this opportunity to thank you for your letter of April 19 and the extensive material that came out of the April 18th hearings.

We would be very grateful for additional statistical information on the incidences of failures of the pathology portion of the optometric licensing exam, as well as case studies showing patient harm from the illegal use of diagnostic or therapeutic pharmaceutical agents by optometrists. To date, I realize, the problems that have been cited have arisen from optometric misdiagnosis. Even those cases could be helpful in other states, since optometrists claim they are competent to diagnose and treat eye problems.

I appreciate the information on Alaska and only regret that the more recent version does not contain photographs of the famous Skagway dance hall queen!

Sincerely,

Henry L.D. Ebert

HE:mlp

P.S. Please keep me posted on the second round of hearings on HB 225. Thanks.

JAMES H. PATTERSON, M.D.
A Professional Corporation
Subspecialty Pediatric Ophthalmology
3500 LA TOUCHE
ANCHORAGE, ALASKA 99504

April 24, 1984

RECEIVED

APR 27 1984

Josephson

Senator Joseph P. Josephson,
Pouch V,
Juneau, Alaska 99811.

Dear Senator Josephson:

As a physician, I am opposed to HB 225 which redefines the practice of optometry and allows the use of legend drugs for diagnostic purposes. I feel that this legislation does not command a wide range of public support and interest and has been conceived, lobbied and financed by organized optometry in order to further its own goals. My reasons for opposing this legislation include the lack of any true need for optometrists to use medications in performing their jobs and dramatic lack of didactic and clinical skills of optometrist in the field of medicine.

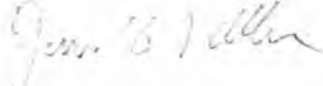
Having actively opposed this legislation since introduction, I cannot help but feel this year it has gained unwarranted and undeserved momentum. HB 225 as written lacks sufficient checks and balances to become an efficient and safe law for the people of Alaska. Amended HB 225 also contains inconsistencies, ambiguities and contradictions.

The two most glaring deficiencies are that this legislation lists legend drugs in broad categories. I feel that if drugs are to be used, they should be identified by specific name, concentration and dosage schedule. Secondly, HB 225, allows the board of optometry and this board alone to decide what legend drugs are to be used and by whom. Regardless of how noble the intentions of the board of optometry are in deciding these matters the practicality and limitations of such a policy should be self evident. In my opinion, the board of optometry should answer to and seek approval of specific drugs from the board of pharmacy and medicine. Since the amended bill lists only cyclopegics and mydriatics, section 5 as 08.7300 paragraph 5 and 6 do not apply.

Again, I am opposed to this bill and feel it should not pass in any form. If you do see fit to pass this I urge you to modify its present form significantly.

I thank you for allowime me time to testify before your committee. I hope you will review my correspondence and references that I have sent you concerning this legislation. I want to offer my services to your committee on medical matters concerning this legislation.

Sincerely,

A handwritten signature in cursive script, appearing to read "James H. Patterson".

James H. Patterson M.D.
JHP/ez

April 21, 1984



STEVEN S. DOBSON, O.D.

[RECEIVED]

APR 24 1984

Josephson,

The Honorable Joe Josephson
Alaska State Senate
Room 508 Capitol Building
Juneau, Alaska 99811

re: CS HB 225 am

Dear Senator Josephson:

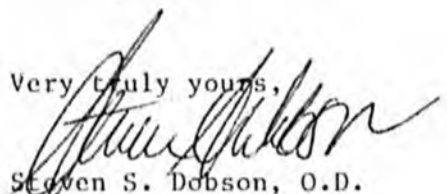
I would like to clarify a point about which there was some confusion during the HESS hearing on April 18, 1984 on HB 225.

While anyone can use an over the counter drug for treatment purposes, to charge a fee to render the treatment or recommend a drug constitutes the practice of medicine under AS 08.64.380 (2). Under existing law therefore, an optometrist must do any therapeutic procedures for free. By adding the diagnosis and treatment language to the definition of an optometrist, the bill provides the needed statutory exemption as required under AS 08.64.170 (a) (4), ("A person who is licensed or authorized under another chapter of this title may engage in a practice that is authorized under that chapter.") However this provision is of limited utility as a result of the Milo Fritz House amendment that eliminated all therapeutic drugs from the legend drug section. (Copy of CS before amendment is attached.)

It is also worth noting, in regard to Dr. Perry's comment about needing to be able to open the chest and perform heart massage, that no dentists and few physicians can competently perform this procedure.

We would like to see the therapeutic drug categories restored, as this will restore the 95% of the public benefits eliminated by the Fritz amendment.

Very truly yours,


Steven S. Dobson, O.D.
Legislative Committee
Alaska Optometric Association

cc: Senators Vic Fischer
Pappy Moss
Rick Halford
Paul Fischer

Millett Keller Company

921 West 6th Avenue
Anchorage, Alaska 99501
(907) 279-8441

April 24, 1984

RECEIVED

APR 30 1984

Josephson,

Senator Joe Josephson
Health, Education and
Social Services Committee
Pouch V, MS 3100
Juneau, AK 99811

Re: HB225

Dear Senator Josephson:

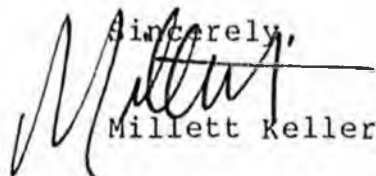
The purpose of this letter is to pass on some comments regarding HB225, particularly a personal perspective I have on this issue.

Both my father and brother are Optometrists, my father practicing in Montana and my brother in Utah. As a result of their professional background and our family relationship, I have been aware of the issue of the use of therapeutic and diagnostic drugs by Optometrists and the opposition to such practices by the Ophthalmology profession.

I am sure you have been made aware that there is no scientific or academically corroborated data which supports the contention that the use of these topical drugs by Optometrists poses a risk to the public health. It has been my perception that the major opposition is based on business practice issues rather than health or safety.

The role of competition and regulation in a free market economy is a very sensitive matter for all the professions. I believe that legislation which regulates business practices should be based on factual evidence that third party interests (namely, the public health) must be protected. Whenever legislation is based on protecting the vendors and providers, it defies the consumer and is, therefore, injurious to a free market society.

It is my understanding that HB225 has been rendered impotent by the House HESS Committee at the specific request of the Ophthalmology profession. I would urge you and your committee to examine the scientific and medical evidence as well as the business issues and use this information when crafting the appropriate language for HB225 which best serves the public interest.

Sincerely,

Millett Keller

MK/pnt

Dr. Roy A. Box
Doctor of Optometry
Professional Plaza Suite A 102
9309 Glacier Hwy
Juneau, AK 99801
Telephone (907) 789-3175

RECEIVED

APR 27 1984

Josephson,

April 24, 1984

Senator Joe P. Josephson
Pouch V
Juneau, Ak 99811

Dear Senator,

I am writing concerning House Bill 255 and would encourage you to support and vote for the original version of this bill. Four states now provide for therapeutic drug use by optometrists and somewhere around forty states allow diagnostic drug use by optometrists. The trend is obviously growing and no evidence exists to show that patients have any more problems with optometric treatment than they do with eye physician treatment. You have to know that competition in any field improves quality of service and tends to reduce cost. This is an important aspect of this legislation when you consider that physicians's fees and hospital costs are increasing faster than the rate of inflation and competition even in this limited specialty might help to reduce this trend.

This whole issue can be condensed into two basic issues, one is might and the other is right. There is no way thirty optometrists can generate as many public opinion phone and telegram messages to legislators as can several hundred or a thousand physicians, so if the only goal of legislators is re-election then might and political clout must prevail. The other issue is right! Is it right to give Alaskans freedom of choice of practitioners when training is adequate to provide good service and no evidence exists to show one discipline is better or worse than the other? There is a vast difference between rhetoric and evidence. Organized medicine with all of its might has not proven their opposition to therapeutic drug use by O.D.'s is wrong and detrimental to any thing but their bank accounts.

I would urge you to consider the fact that village health aids and P.A.'s routinely handle and dispense drugs for a wide variety of conditions from very well stocked drug supplies without much if any "medical" supervision and with little or no adverse side effects or improper diagnosis. The product description for legend drugs in the P.D.R. is over 1,500 pages. The same section in the P.D.R. for ophthalmology is 100 pages and includes descriptive information on over the counter agents and soft contact lenses. The actual drug choices are few and not difficult to become familiar with.

I would urge you to support legislation to allow doctors of optometry to use therapeutic and diagnostic agents or work against this legislation if political muscle is your important consideration in the legislation you support.

The physicians are also claiming some kind of a compromise on this legislation



Member

American Optometric Association

Dr. Roy A. Box
Doctor of Optometry
Professional Plaza Suite A 102
9309 Glacier Hwy
Juneau, AK 99801

Telephone (907) 789-3175

Page 2

in 1980 insisting I agreed to the compromise. They either have very short memories or a propensity for changing the facts to suit their purposes. The only agreement was that the physicians were going to go back to their group and the optometrists would go back to theirs and offer grounds for a compromise. The physicians were to contact us first and we never heard from them so the matter was dropped. I only agreed to discuss their concerns with my group. NOTHING ELSE! Rick Urion was the Optometric Association lobbyist at the time and can verify my recollection of the meeting.

Sincerely,


Roy A. Box, O.D.



Member

American Optometric Association

BRISTOL BAY AREA HEALTH CORPORATION

P.O. Box 10235
DILLINGHAM, ALASKA 99576

PHONE: (907) 842-5201
(907) 842-5202

April 16, 1984

RECEIVED
APR 27 1984
Josephson,

Senator Joe Josephson
Chairman; Health, Education and
Social Services Committee
Room 508, Capitol Building
Juneau, Alaska 99811

Dear Senator Josephson:

House Bill 225 has been referred to your committee for consideration. This Bill as ammended in the House has circumvented the Bill's original intent.

The original legislation was designed to authorize the use of diagnostic and theraputic pharmiceuticals by appropriately licensed optometrists. Its scope has been significantly narrowed by ammendment in the House.

I support the original intent of the bill and ask that the Senate consider the pre-ammended legislation for passage.

Passsage of the intact House Bill 225/Senate Bill 189 will be of undeniable benefit for the citizens of our area. It will increase the availability of eye care and be very cost effective.

Thank you for your consideration of this matter.

Sincerely yours,



Robert J. Clark
Executive Director

RJC:sf

cc: Senator Vic Fisher
Senator Paul Fischer
Senator Pappy Moss
Senator Rick Halford
Dr. Jim Pickard, O.D.
Robert J. Clark's File
Reading File
File

(Part Two)

TESTIMONY IN SUPPORT OF SENATE BILL 189

Health, Education and Social Services Committee

Alaska State Senate

April 13, 1983

Steve Dobson, O.D.

Gentlemen of the Committee, my name is Steve Dobson. I am an optometrist in private practice in Anchorage. I am a 1980 graduate of the Southern California College of Optometry, and in 1981 completed a one year residency in rehabilitative optometry at an outpatient clinic of the Veterans Administration hospital in Los Angeles.

My testimony will focus on optometric education, for the most frequent charge raised by ophthalmologists in opposing this type of legislation is that optometrists do not have a physician's broad medical background, which they say is necessary in order to do competent diagnosis and treatment.

It so happens, like many propaganda arguments, that this one has a grain of truth in it. What may appear to be a local inflammation can actually be a manifestation of infection or dysfunction elsewhere in the body. Experience in administering a variety of drugs in a variety of modes makes it easier to learn new drugs and new treatment protocols.

However if the argument is carried too far, it begins to break down. One can say that it is useful to be trained as a general physician before treating specific parts of the body. But is it absolutely necessary? Ophthalmologists, who are trained on the physician-specialist model, would say that a physician's background is necessary even to be able to judge when to treat a case and when to refer it for more specialized care. However it takes no special expertise to realize that if that were the case, then dentists and podiatrists, who are not trained as physicians, would be incompetent or only marginally competent.

Let's take a closer look at the alternative model of education, on which dentists, podiatrists and optometrists are trained. For convenience, I will consider just dentistry and optometry, but podiatry follows similar principles. Dentists and optometrists have at least as many hours of training in anatomy as physicians. But that training is structured differently. Their studies in gross human anatomy give somewhat less emphasis to the body below the neck but more emphasis in the head and neck region, as compared with medical students. This is followed by intensive study of organ systems of special interest - the teeth and oral cavity for dentists, the eye and adnexa for optometrists. This is a level of detail that physicians do not encounter until they enter specialty residencies. Other courses, such as general

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physiology, microbiology and general pathology, are also slightly less detailed than those given medical students. But again, when corresponding studies in the target organ systems are added in, the hours exceed those of the medical student. If we take the process one step further and add the hours of the medical student and the resident together, the total hours in any given subject would now be greater than those for the dentist and optometrist. For optometry and dental students, classroom and laboratory time in these subjects, called basic science, totals about a thousand hours, or 25% of the total clock hours in the curriculum. The remainder is given over to specialized theory and procedures courses, and experience in the clinic.

At this point, let me interject that in case it should be supposed or alleged that optometric courses are not of the same quality as dental courses, I would point out that where optometry and dental schools are co-located, as at the University of Alabama in Birmingham and the University of Houston, optometry and dental students not only take the same courses but sit together in the same classrooms and laboratories whenever there is enough commonality in content to make this practical. For example, general physiology and microbiology in the case of Birmingham. In both optometry and dental schools, physicians are used in their areas of greatest expertise, primarily pathology and therapeutics. Pharmacology is taught by pharmacologists and physiology is taught

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Apr. 13
Dobson, p.4

by physiologists.

Courses in the whole body emphasize unifying principles, which serve as a foundation for understanding all regions. At the stage of target organ study, specific interrelationships between target organ pathology and systemic pathology are learned. It is also at this stage that the student learns what effects a drug may have on other organs of the body.

Without putting too fine a point on it, it is hopefully evident from this that someone who will be working with a portion of the body and dealing with a specific set of interrelationships between this portion and the rest of the body does not have to have the same kind of whole body training as someone who will be treating many different parts of the body. The specializing physician model of education is a good one, but is it enough better than the dental model to justify the increased costs?

With respect to drugs, however, optometry has differed from dentistry until recent years. When the optometry laws were enacted in the first quarter of the century, restrictions against drug use were inserted into nearly every statute as a compromise with the physicians and oculists of the day, who opposed enactment of the optometry laws. In the succeeding years, optometry developed strong capabilities in the detection and diagnosis of ocular

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pathology, but its lack of access to prescription drugs effectively limited its therapeutic services to conditions treatable with over the counter drugs, compresses and mechanical procedures. During the same period, ophthalmology developed from a primitive extension of general medicine into a recognized specialty. In the 1970s general and ocular pharmacology were removed from their positions within other courses in the optometric curriculum, and expanded into full fledged, free standing courses. Concurrently, optometrists introduced bills that would allow them to use drugs to aid in diagnosis, on the theory that such limited legislation would be easier to pass. There began a slow, state by state process of passing legislation, against fierce ophthalmological opposition. As of now, 36 states allow some form of drug use by optometrists. In 1976, West Virginia became the first state to enact legislation allowing optometrists to use drugs for both diagnostic and therapeutic purposes. In 1977, North Carolina passed a similar measure and Florida received an attorney general opinion favorable to the use of therapeutics. In 1980, Oklahoma passed enabling legislation. In support of these states, nearby optometry schools strengthened their programs in therapeutics. At present, drug-based therapeutics is taught at an undergraduate and postgraduate level by Pennsylvania College of Optometry in Philadelphia and Southern College of Optometry in Memphis, and by the University of Alabama at Birmingham School of Optometry on a postgraduate basis. Other schools are planning similar programs. Pennsylvania's therapeutics course was taken by a

majority of Alaska's ODs last year. Opportunities for additional clinical experiences in therapeutics developed quickly and dramatically. Federal law in 1976 formally established Optometry Services within the Veterans Administration hospital system. These Optometry Services provide primary eye care therapeutics, usually under the prescription signing arrangement noted by Dr. Demske. A number of the Services have developed 1 year residency programs for optometrists, such as the one I went through. Opportunities are also available for ODs and undergraduate optometry students to study at these hospitals for shorter periods of time. In Atlanta, there is a three year old optometric clinic that does nothing but treat ocular pathology on referral from physicians and optometrists in the area. Students from four optometry schools do semester rotations there, and similar centers are being planned in other cities. There is thus developing a spectrum of training opportunities, both basic and advanced, for optometrists in therapeutics.

It appears that at long last the quirks of the original optometry laws are being removed and optometry will be allowed to undergo a more natural evolution. Optometry will continue to compete with ophthalmology, as podiatry competes with orthopedic surgery, though in the case of optometry, surgical training is not on the horizon. While the medical branches may not like it, such competition is good for the public. Optometry, like podiatry, can now offer quality, cost effective services in areas where specialists are overtrained

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Senate HESS
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and general practitioners are undertrained. Dentistry has no competition from medicine, but its training is also based on the more cost effective model.

One more thing needs to be said. Ophthalmologists have criticized other aspects of optometric education, saying that there are too few MDs teaching in optometry schools and that clinical experiences are not adequate. In point of fact, ophthalmologists have actively tried to hinder the education of optometrists. There is a great deal of peer pressure on ophthalmologists, and through them, on their colleagues in other branches, not to teach in optometry schools. In 1955, the American Medical Association, at the request of the Section on Ophthalmology, adopted a resolution declaring it unethical for a doctor of medicine to teach in a school or college of optometry. Such resolutions have more than nominal influence upon physicians, for unethical behavior can serve as the basis for denial of hospital privileges by individual hospital medical staffs. Some physicians ignored the directive and continued to teach, and schools filled in the gaps by using osteopaths, who were not affected. The resolution was rescinded 11 years later, in 1966.

Ophthalmology has also opposed virtually every piece of legislation that would facilitate the professional development

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of optometry, including funds for construction of optometry school buildings and clinics, Health Professions Student Loans, and capitation grants. Fortunately, most Congressmen and legislators saw the value of optometry to society, and the efforts of ophthalmology to block funding were largely unsuccessful. From 1964 to 1980, ophthalmologists were able to prevent reimbursement to optometric patients for services covered under Medicare. As a result, optometry lost 30% of its patient population over age 65. It also deprived optometry school clinics of a prime source of pathology for teaching purposes. It is not fair to criticize something when you are actively trying to bring about that which you criticize.

In conclusion, I would ask that you allow optometry in Alaska to take full advantage of the educational opportunities that are unfolding, so as to maximally benefit the public which it serves. Overly restrictive compromises will simply result in further legislative battles down the road. The bill in its present form conforms to the framework for decision making that has stood the test of time in other professions. It makes no legislative sense to take a responsible profession out of one box and place it in a slightly larger box. Given the opportunity, optometry will exercise the same good judgment as the other professions. And the public will be the beneficiary.

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

RECEIVED

APR 15 1983

April 4, 1983

Josephson,

The Honorable Mae Tischer
Alaska State Senate
Fouch V
Juneau, Alaska 99811

APR 1 1983

Dear Representative Tischer:

I would like to offer my support for HB 225 and SB 189 which would permit appropriately trained and licensed optometrists to use prescription ophthalmic drugs for diagnosis and treatment of eye problems.

I work closely with two optometrists in Bethel, John Demske, O.D., and James Taylor, O.D., who are authorized under standing orders approved by the medical staff of the Yukon Kuskokwim Delta Regional Hospital to use certain prescription drugs for the diagnosis and treatment of eye disorders. They also work under the indirect and direct supervision of the Ophthalmology Department at the Alaska Native Medical Center in Anchorage. John Demske has been operating under these standing orders for almost five years without mishap. Both optometrists have made a substantial contribution to the increased quality of eye care in this region. The physician staff respects their knowledge and expertise and regularly consults them regarding eye problems.

The Ophthalmology Department at the Alaska Native Medical Center has recommended that the eye care program operating in this region be considered as a model for other Service Units in the Alaska Area Indian Health Service. This recommendation has been supported by the Service Unit Directors and Clinical Directors of the Alaska Area.

The backbone of the health care system in rural Alaska has been trained paramedical personnel, including Physician Assistants, Nurse Practitioners, Public Health Nurses, Community Health Aides, and in this area, the Optometrists with the YKHC Eye Care Program. They have proved themselves vital in achieving otherwise unobtainably high standards of health care in remote areas. The professional performance of the optometrists in this region has been excellent. They have provided quality eye care services otherwise unavailable to the people of the Delta. They have recognized their limitations and always referred patients when appropriate.

To: Senate HESS

From: Rep Tischer

for file on
optometry
(SB 189)

Constituent letters re: HB 225/
SB 189.

Based on my experience with optometrists using prescription ophthalmic medications for specified diagnostic and therapeutic purposes in this area I am inclined to agree that the major obstacle to a more extensive utilization of the optometrists' special skills and knowledge is a financial one rather than a primary concern for the quality of eye care available to the people of the state.

I strongly endorse SB189 and HB 225. If I can be of any further help, please let me know.

Sincerely,

John Wetherby
John Wetherby, M.D.

P.O. Box 452

Kenai, Ak

99611

APR 11 1983

Dear Ms. Tischer,

I am writing to encourage
you to vote Yes on House Bill
225.

It is my belief that bill
225 is important to the health
care of Alaskans.

Sincerely Yours,

Teresa Youngren

YUKON-KUSKOKWIM HEALTH CORPORATION

P.O. Box 528
Bethel, Alaska 99559
(907) 543-3321

April 8, 1983

APR 12 1983

The Honorable Mae Tischler
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischler:

I'm writing to you about HB225, relating to the use of drugs by optometrists. I support this bill and hope that it will be passed.

I work for YKHC in the eye clinic and routinely use eye drops for dilating patients. I have yet to see any undesirable effects from these drops.

Living in rural Alaska, this bill could only be beneficial. Major pathology can be detected earlier and thus save someone's eyesight.

Please support this bill.

Sincerely,
Louise A. Wilder

APR 1 1983

4. 7. 83
WAYNE HOWE
1021 W. 12TH
ANCHORAGE, AK 99501

APR 11 1983

Ms. TISCHER,

I URGE YOUR SUPPORT OF THE
OPTOMETRIST'S DRUG BILL. IT WILL BE
REALLY HELPFUL IN AREAS WITHOUT SPECIALISTS,
WHERE THE GENERAL PRACTICE DOCTOR MUST
PROVIDE TREATMENT WITH FAR LESS EYE
TRAINING THAN THE OPTOMETRIST. WE
NEED BETTER AVAILABILITY OF EYE CARE
IN ALASKA.

Thank You
Wayne R. Howe

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

April 8, 1983

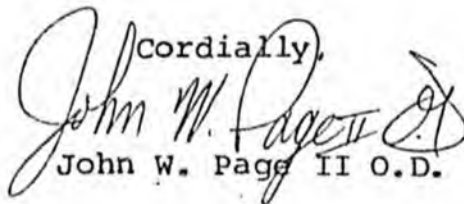
APR 11 1983

Rep. Mae Tischer
Chairperson, House HESS Committee
Pouch V
Juneau, Alaska 99801

Dear Rep. Tischer,

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

Visual Training
Contact Lenses

Ed Craig, O.D.
Doctor of Optometry
348 Main Street
Ketchikan, Alaska 99901
Telephone (907) 225-3975

April 8, 1983

APR 11 1983

Representative Mae Tischer
c/o Health, Education and Social Services
Pouch V
Juneau, Alaska 99811

Dear Rep. Tischer;

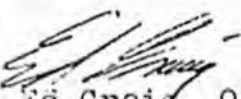
As a practicing optometrist of some 28 years in the Ketchikan area, I have many times been requested by patients to remove foreign objects embedded in their corneas and adjacent areas of the eye, treat scratches and scrapes of the eye, look after infections caused by bacterial or viral agents, etc., only to have to tell the patient that I am unable to help them - not because I do not have the knowledge, or skill - but because the law is such that it says, "NO! you may not."

Were I able to render immediate assistance to these patients, their recovery would be that much faster. Instead, I refer them to a physician's office where the patient waits his turn, perhaps for several hours, before receiving attention.

From an economic standpoint it is a waste to restrict highly, well-trained professionals from using only a part of their capabilities.

I am therefore in favor of passage of House Bill #225.

Very truly yours,


Ed Craig, O.D.
EC/vc



Member
American Optometric Association

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PRESIDENT

Dennis A. Swarner, O.D.
Drawer 4370
Kenai, Alaska 99611
April 8, 1983

APR 11 1983

Mae Tischler
Pouch V
Juneau, Alaska 99811

Dear Ms. Tischler;

I am writing to urge your support of House Bill #225, an act relating to the Practice of Optometry.

It is time that Optometrists in Alaska are treated like other health professions. The educational background of Optometrists is similar to that of dentists and podiatrists, professionals who have unrestricted drug prescribing privileges, other than those imposed by their respective boards.

The statutes restricting drug use by Optometry were written when the laws were first enacted. In view of the current education of Optometrists, these laws are now outdated.

This bill is being opposed by a small group of Physicians, for what I believe to be economic reasons. If it was for the economy of the patient, there might be some merit in the opposition. But the passage of this bill will save our patients time and money, by avoiding unnecessary referrals.

As President of our Association, I would like to thank you for considering this bill, and I hope you find it prudent to allow our Board to regulate Optometry in the same manner that those who oppose it are regulated by their board.

Regards;



Dennis A. Swarner, O.D.

Mae Tischer
Representative District 11
3305 Oregon Drive
Anchorage, Alaska 99503

APR 11 1983

April 7, 1982

Dear Representative Tischer;

I am a Physicians' Assistant practicing in the State of Alaska and am writing to you to voice my support of HB 225.

I have been a Physicians' Assistant for four years and have worked in states that have legislature allowing Optometrists to use pharmaceuticals in the diagnosis and treatment of eye disorders. I frequently refer patients to them and have been pleased with the quality of care and have had positive feedback from those patients.

I have found that the limitations placed on them by not allowing them to use pharmaceuticals in their practice somewhat of a handicap.

I hope that when this bill comes before the house that you will support it.

Thank you for your kind consideration in this matter.

Respectfully,

Barry L. Campbell

Barry L. Campbell PA-C

APR 12 1983

April 9, 1983

Representative Mae Tischer,
Chairman, Health, Education
and Social Services
Alaska State House of Representatives
Fouch v
Juneau, Alaska 99811

Dear Representative Tischer

I wish to offer my support for House
bill # 225 and urge that you do likewise. I know
that optometrists are more than qualified to
decide when to treat and when to refer. It
makes no sense to me to give ophthalmologists
exclusive right to treat minor eye infections and
charge high fees when they already make
more money in one day of surgery than most
working people do in a month.

Please support this bill. Thank you.

Very truly yours,

Mrs. Michael Brandenburger

Box 216 Chuchagot Ap
Eagle River, Alaska
99577

April 8, 1983

APR 11 1983

Dear Ms. Tischer:

I strongly urge you to support the optometry drug bill. I feel that this will better enable my optometrist to serve the needs of my family.

Thank you,

Sara Castle

Sara Castle

3700 Arkansas #13

Arch 99503

APR 11 1983

April 4, 1983

The Honorable Mae Tischer
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

I would like to offer my support for HB 225 and SB 189 which would permit appropriately trained and licensed optometrists to use prescription ophthalmic drugs for diagnosis and treatment of eye problems.

I work closely with two optometrists in Bethel, John Demske, O.D., and James Taylor, O.D., who are authorized under standing orders approved by the medical staff of the Yukon Kuskokwim Delta Regional Hospital to use certain prescription drugs for the diagnosis and treatment of eye disorders. They also work under the indirect and direct supervision of the Ophthalmology Department at the Alaska Native Medical Center in Anchorage. John Demske had been operating under these standing orders for almost five years without mishap. Both optometrists have made a substantial contribution to the increased quality of eye care in this region. The physician staff respects their knowledge and expertise and regularly consults them regarding eye problems.

The Ophthalmology Department at the Alaska Native Medical Center has recommended that the eye care program operating in this region be considered as a model for other Service Units in the Alaska Area Indian Health Service. This recommendation has been supported by the Service Unit Directors and Clinical Directors of the Alaska Area.

The backbone of the health care system in rural Alaska has been trained paramedical personnel, including Physician Assistants, Nurse Practitioners, Public Health Nurses, Community Health Aides, and in this area, the Optometrists with the YKHC Eye Care Program. They have proved themselves vital in achieving otherwise unobtainably high standards of health care in remote areas. The professional performance of the optometrists in this region has been excellent. They have provided quality eye care services otherwise unavailable to the people of the Delta. They have recognized their limitations and always referred patients when appropriate.

I strongly endorse SB189 and HB 225. Thankyou for your time.

Sincerely,

Jill Seaman

Jill Seaman, MD

*DHS Hqs
Bethel*

APR 11 1983

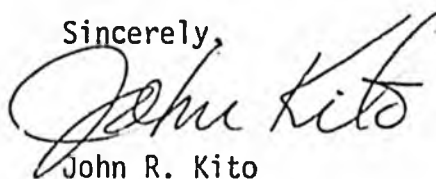
SRA Box 1026-B
Anchorage, Alaska 99502
April 7, 1983

Honorable Mae Tischer
Co-Chairman, House HESS Committee
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

Please support HB 225/SB 189 allowing use of ophthalmic drugs by optometrists. This legislation is in the best interest of the people of Alaska in saving money and time, especially for "bush" residents.

Sincerely,



John R. Kito

APR 12 1983

April 4, 1983

The Honorable Mae Tischer
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

I would like to offer my support for HB 225 and SB 169 which would permit appropriately trained and licensed optometrists to use prescription ophthalmic drugs for diagnosis and treatment of eye problems.

I work closely with two optometrists in Bethel, John Demske, O.D., and James Taylor, O.D., who are authorized under standing orders approved by the medical staff of the Yukon Kuskokwim Delta Regional Hospital to use certain prescription drugs for the diagnosis and treatment of eye disorders. They also work under the indirect and direct supervision of the Ophthalmology Department at the Alaska Native Medical Center in Anchorage. John Demske has been operating under these standing orders for almost five years without mishap. Both optometrists have made a substantial contribution to the increased quality of eye care in this region. The physician staff respects their knowledge and expertise and regularly consults them regarding eye problems.

The Ophthalmology Department at the Alaska Native Medical Center has recommended that the eye care program operating in this region be considered as a model for other Service Units in the Alaska Area Indian Health Service. This recommendation has been supported by the Service Unit Directors and Clinical Directors of the Alaska Area.

The backbone of the health care system in rural Alaska has been trained paramedical personnel, including Physician Assistants, Nurse Practitioners, Public Health Nurses, Community Health Aides, and in this area, the Optometrists with the YKDC Eye Care Program. They have proved themselves vital in achieving otherwise unobtainably high standards of health care in remote areas. The professional performance of the optometrists in this region has been excellent. They have provided quality eye care services otherwise unavailable to the people of the Delta. They have recognized their limitations and always referred patients when appropriate.

Based on my experience with optometrists using prescription ophthalmic medications for specified diagnostic and therapeutic purposes in this area I am inclined to agree that the major obstacle to a more extensive utilization of the optometrists' special skills and knowledge is a financial one rather than a primary concern for the quality of eye care available to the people of the state.

I strongly endorse SB189 and HB 225. If I can be of any further help, please let me know.

Sincerely,

David Clement MD

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

Testimony In Support of Senate Bill 189
Health, Education and Social Services Committee

Alaska State Senate

April 13, 1983

John Demske, O.D.

Good afternoon, My name is John Demske, and I am an optometrist employed by Yukon-Kuskokwim Health Corporation in Bethel. In this capacity, I and another optometrist provide primary eye care services at the Public Health Service Hospital in Bethel and at field clinics throughout the Yukon-Kuskokwim delta. We routinely use prescription drugs through the use of standing orders.

I would like to outline some role relationships and practitioner competencies in eye health care as they relate to the bill under consideration today. Later, my colleague, Dr. Steve Dobson, will discuss optometric and dental models of education as they relate to medical training.

I will start with four concrete examples that illustrate the kinds of knowledge and equipment needed in providing primary eye care.

First, I would like to relate a recent case from my practice. Last Sat. April 9th, I was called at home by one of the General Physicians in regard to a patient, Mr S. The Physician involved, Dr.X. has consented to my using this experience as an example in testimony as he is in support of this legislation. Mr S. Initially presented to Dr.X. on Saturday April 2nd in the emergency room. He complained that he felt something in his left eye. He also reported that he thought he might have scratched his eye the previous evening. Pertinent medical history is that Mr S. is confined to a wheelchair from rheumatoid arthritis, ankylosing spondylitis and a spinal injury. His right eye is blind from glaucoma:

April 13, 1983

Demske, P.2

He had cataract surgery in his left eye in 1976. His current medications are methadone and a prescription for his arthritis. Dr. X diagnosed a corneal abrasion with the use of sodium fluorescein. He reassured Mr S. and told him to report to the optometry clinic on Monday the 4th if his eye didn't improve. No medications were prescribed. Mr S. returned 1 (one) week later, Saturday April 9th. He stated his eye was getting worse. When asked why he had not returned earlier, he reported that initially his eye felt better and that it didn't get worse until that morning. Dr X thought that Mr. S. may have developed a corneal ulcer and he consulted me.

My examination revealed a definite corneal ulcer and a moderate iritis, his vision was 20/25. I worked up the patient as a bacterial corneal ulcer. The laboratory studies confirmed my diagnosis. I consulted with an ophthalmologist and reported my findings, diagnoses and the laboratory results, I strongly recommended that Mr S. be admitted to the hospital. He concurred and recommended a treatment regimen. The ulcer and iritis are healing well but Mr S. remains hospitalized. As it is his only seeing eye and it is questionable if he can adequately care for himself. The plan is to keep him hospitalized until the ulcer is totally healed.

This case is a perfect example of what can happen to a corneal abrasion. Optometrists see corneal abrasions secondary to contact lenses routinely in their practices. With their expertise with a slit lamp/biomicroscope, they can determine the depth and severity of a corneal abrasion. This instrument is also necessary to diagnose iritis an inflammation of the iris. Dr X did not use a slit lamp/biomicroscope as he is unfamiliar with it.

Many mild corneal abrasions will heal spontaneously without treatment, some will progress to an ulcer. A short course of a topical antibiotic for prophylaxis will prevent an ulcer. Dr X a General Practitioner had the option to treat the abrasion. Optometrists in private practice have the option to refer to a physician for treatment Dr X referred Mr S. to a doctor of optometry.

Second, A herpes simplex infection of the cornea may resemble simply a red eye, because there is often relatively little pain. However if eyedrops containing steroids are used to reduce inflammation and whiten the eye, the sever-

SB 189
Senate HESS
April 13, 1983
Demostre, P3

ity of the corneal infection will be dramatically increased, and can lead to a scarring stromal ulcer. In the early stages of an hermetic involvement, a biomicroscope is needed to see the characteristically branching lesion and distinguish it from other types of corneal involvement. This microscope is used routinely by optometrists and ophthalmologists but is not found in offices of general physicians.

Example number three, A lump in the eyelid resembling a styne may be a swelling of an oil producing meibomian gland. The condition is called a chalazion. The first treatment of choice is not a drug but a hot compress. However anyone providing primary eye care should not simply be ignored, but should be evaluated by a specialist for the possibility that it might be a carcinoma of the meibomian gland. The specialist can also do lancing and expression of the contents of the gland; if indicated.

A fourth example; A generalized swelling and inflammation of the eyelids without pain on movement of the eye may be a condition known as pre-septal cellulitis.

It generally requires oral antibiotics for effective treatment. However anyone providing primary eye care should know that a possible complication is extension of the inflammation past a protective septum and on into the orbit, characterized by pain on moving the eye. This is orbital cellulitis. The infection can then follow the sheath of the optic nerve and lead to meningitis, a much

more serious complication. It is unlikely that a general physician is aware of this possible sequence of events.

I have used these examples not to run down the general physician but to emphasize that there is only so much that he can know. In the busy medical school curriculum, the average medical student receives less than 25 clock hours of instruction in the eye and its treatment. This includes anatomy and physiology of the eye, examination techniques, ocular pathology, treatment and management of eye conditions. By contrast, the optometrist receives hundreds of hours in these subjects, plus specialized clinical experience. It does not matter how much kidney disease a general practitioner treats, or how many broken arms he sets or babies he delivers, if he does not know the specifics of ocular syndromes or have the proper equipment, he cannot be a good diagnostician of the eye.

The other relevant comparison is between the optometrist and ophthalmologist. The ophthalmologist considers himself to be primarily a surgical specialist, but in the course of his post-medical school surgical training, he also receives extensive exposure to diagnosis and treatment of non-surgical eye conditions. He typically sees more pathology in his hospital based residency than most optometry students see in the pathology portions of their outpatient clinics. His academic preparation, on the other hand, is less extensive than that of the optometrist, currently consisting of 6 weeks of academics at an east

or west coast university.

These role relationships can best be seen in institutional settings, where fixed salaries eliminate economic competition factors and workloads, promote professional cooperation, competition. include military hospitals, Veterans Administration hospitals, HMOs and Indian Health Service facilities. In such settings, if an ophthalmologist is on staff, eye ailments of a more serious nature are referred to him for evaluation and treatment. If an optometrist is on staff but no ophthalmologist, the optometrist receives the referral and his advice is sought. However if a drug is to be prescribed, the optometrist cannot sign the prescription, for in most states only physicians, dentists or podiatrists can sign a prescription. So the prescription is signed by the general physician or non-eye specialist, who knows less about the condition, the treatment or the drug than does the optometrist.

Thus the optometrist, both by training and in practice, occupies a position between the general practitioner and the ophthalmologist, though closer to the ophthalmologist.

This analysis leads naturally into another question: if diagnostic and treatment abilities vary among practitioners, should not the licensing system attempt to define specific areas of

competance and specify the treatments which can or cannot be performed? Traditionally the profession of medicine has enjoyed unlimited licensure under the broad statutory definition of treating the sick and injured. Professions of more limited scope such as dentistry, podiatry and optometry have statutory definitions using an organ level of specificity rather than, say, specific structures or parts of organs. In each case, it is left to the profession to decide whether a given condition should be treated by a generalist, specialist or subspecialist. This is appropriate, for reasons I will give in a minute. It is very significant that for every profession that has drug prescribing authority, there is no statutory specification as to the allowable drugs or even the classes of drugs. That is to say, each practitioner's prescribing authority is theoretically unlimited. I say theoretically, because each group tends to limit itself, on a common sense basis, to drugs which are appropriate to its field of endeavor. This allows them to be quite adept at using this narrower spectrum of drugs. A listing of drugs or procedures in statute is unnecessary and would quickly become obsolete. Where very specific restrictions are appropriate, they are imposed by the respective boards, whose members know what is going on in their field's educational system. Thus for a dentist to use general anesthetics, the dental board requires, by regulation, that he have a year of postgraduate training in this area, for general anesthesia is a very tricky procedure. Prescribing abuses by MDs and dentists tend to be in the area of controlled substances, for there is a large illicit market for controlled substances.

However, such prescribing is closely monitored by the federal Drug Enforcement Administration, and few practitioners get away with abuses for long.

I mentioned a moment ago that it is appropriate for each profession to decide how to handle different levels of treatment. Unlimited licensure needs to be preserved for two reasons: first, a practitioner in a rural area needs to have the legal freedom to treat somewhat more specialized problems when a specialist is not available in his area. He is frequently aided in this by telephone consultation with a specialist. This is exactly what I do when a case comes up that needs more specialized expertise. Secondly, no two practitioners have exactly the same knowledge or skills. If a generalist has experience in a given procedure, he may undertake it when another generalist might chose not to do so but instead send the patient to another doctor in another locale. It is this process of intercommunication and interreferral, with practitioner latitude, that makes the system work. Optometry is an integral part of this process, but with the limitations that this bill seeks to redress.

At this point, you may still be moved to ask, do broadly worded statutes provide sufficient protection for the public? In addition to the system I have just described, which incorporates licensing board and federal regulations, and the judgment of the practitioner, there are additional free market constraints upon the behavior of professionals.

Perhaps most important, malpractice considerations dictate that the individual practitioner not practice at or beyond the limits of his expertise, and in any event not deviate significantly from what are considered to be accepted procedures unless he is participating in a carefully defined research project. In addition, medical care is a quality oriented market. Much of it is covered by third party payment plans. There is an attitude that "nothing is too good for my body". The patient thus has every incentive to seek the highest quality care available. If a practitioner is doing slipshod work or not keeping up with his field, patients can sense it and word quickly gets around. It is in the interest of both the individual practitioner and the profession that prepares him to maintain the highest standards of training and practice.

If quality of optometric care can be defended, what about savings to the patient? A truly rationalized system of health care dictates that each practitioner practice at his highest and most efficient level. Under the present system, the doctor of optometry must refer his patient to the ophthalmologist, to be charged a specialist's fee for a primary care procedure. If the OD sends his patient to a general physician with recommendations, there is still a second visit fee. And whether the patient pays the fee himself or is covered by private insurance, Medicare or Medicaid, consumers of health care still ultimately pay the bill. This is why third party payors are now beginning to recommend optometric treatment for primary conditions.

One final thought. You will be asked by opponents of the bill to impose special restrictions on the optometric practice of therapeutics. While we are not dogmatically committed to the exact language of the present bill, we wish to emphasize that most restrictions in statute would set precedents that do not exist for other practicing professions and serve only to maintain a privileged status for a group that is no longer entitled to that status by virtue of exclusive education and training. If you are drawn into attempting to draft specific standards, you will be treated to the opponents' ability to obfuscate, raise red herrings and confuse. It will then be suggested that you refer the matter to a study committee. In other states where this has been tried, it has served to delay passage and increase the number of committee meetings devoted to the subject. There was also the politically charged question of how the committee would be constituted, and the recommendations of the committee have tended to reflect the political allegiances of its individual members, even those representing supposedly neutral groups.

The question this committee and the legislature as a whole must answer is basically a simple one: shall the profession of optometry be treated as a mature profession, capable of making intelligent, informed decisions? I hope that by the time our testimony is completed you will be firmly convinced that it is.

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

JAY S. HAMMOND, GOVERNOR

CHARLES R. RUSH
P.O. BOX 3728
ANCHORAGE, ALASKA

99501

MARCH 9, 1983

DIVISION OF OCCUPATIONAL
LICENSING

POUCH D
JUNEAU, ALASKA
99811

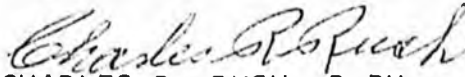
ATTN: HARRY TREAGER

PERTAINING TO HOUSE BILL #225 I WOULD OPPOSE THE BILL AS WRITTEN. FROM A PHARMACY STANDPOINT, IF OPTOMETRISTS ARE GOING TO PRESCRIBE THE SEC. 8-72-277(B) DOES NOT MAKE SENSE AS ALL PRESCRIPTION DRUGS ARE LEGEND DRUGS. POSSIBLY THEY WANTED THIS TO READ THAT THEY CANNOT PRESCRIBE CONTROLLED SUBSTANCES WHICH WOULD CERTAINLY BE A GOOD IDEA AND ALSO THAT THEY WOULD NOT HAVE DEA LICENSES.

IT IS DIFFICULT FOR PHARMACISTS TO HAVE THIS TYPE OF PRESCRIBER WHERE THEY HAVE TO REMEMBER THE PRESCRIBER CAN ONLY WRITE FOR CONDITIONS OF EYES AND EYELIDS AND IF THEY WRITE FOR SOMETHING ELSE THE PHARMACIST MUST CATCH IT AND REFUSE TO FILL. WE HAVE SOME PROBLEM WITH DENTISTS IN THIS REGARD AS THEY CAN ONLY WRITE FOR DISEASES OF THE MOUTH, GUMS ETC, HOWEVER, DENTISTS PRESCRIPTIONS ARE MORE EASILY NOTICED THAN WOULD BE AN OPTOMETRISTS.

WE ALSO HAD THIS PROBLEM WITH PHYSICIANS ASSISTANTS AND NURSE PRACTITIONERS AND WERE FORCED INTO ADVISING THE MEDICAL BOARD THAT WE COULD NOT MONITOR EACH PA'S OR NP'S INDIVIDUAL PRESCRIPTION ALLOWANCES AND THAT THIS WOULD HAVE TO BE CONTROLLED BY THE COLLABORATING PHYSICIAN TO SEE THAT THE PA OR NP ONLY WROTE FOR THE ITEMS THAT WERE AUTHORIZED.

POSSIBLY THERE COULD BE A REQUIREMENT THAT OPTOMETRISTS RX BLANKS CARRY A NOTATION "CAN ONLY PRESCRIBE FOR DISEASES OF EYES AND EYELIDS" EITHER THAT OR HAVE A COLLABORATING PHYSICIAN TO MONITOR THE ITEMS PRESCRIBED.

SINCERELY,
ALASKA BOARD OF PHARMACY

CHARLES R. RUSH, R.P.H.
MEMBER

CRR/JD

MEMORANDUM

State of Alaska

TO: Harry D. Treager
Administrator, DOL

DATE: March 14, 1983

FILE NO:

TELEPHONE NO:

FROM: Margaret Soden
Member, Board of Pharmacy

SUBJECT: HB 225 Practice of
Optometry/Use of Drugs

I have several questions and concerns about this bill that you can perhaps have addressed when it is being discussed in the Legislature.

1. There are apparently going to be two classes of Optometrists- Those who have been approved to prescribe drugs and those who have not. In AS 08.64.170(e) it says that the names of those who can prescribe drugs will be furnished to the Board of Pharmacy. Are we then going to have to issue lists of the nature of their authority to prescribe similar to what we do for PA's and ANP's? We are having a difficult time keeping the pharmacies supplied with current lists of these folks that this will add something new for us to be falling behind on.

2. Under the provisions for the use by optometrists for prescription drugs, is this going to include all drugs or just those which are used as drops or ointments to be applied directly to the eye and which have been formulated for that use. If this is the case, and I think it needs to be spelled out, then I would favor this provision with some reservations. I would not, however, feel comfortable if they could prescribe drugs taken internally since it would definitely be a matter of interpretation as to whether a particular drug's use falls into their scope of expertise. The reason I would favor the use of ophthalmic drops or ointments being allowed is that optometrists sometimes recommend that patients buy certain non-ophthalmic ointments to be used in the eye. (We have such a case in Fairbanks and it is rather difficult to handle at times-the Dr. tells that patient to get Neosporin Ointment which says right on the label "do not use in the eye", the patient asks me if it is safe, the Dr. tells me it is, the manufacturer says it is not-liability reasons, I suppose-so that puts me right in the middle of a messy situation. Do I say go ahead? Do I say NO WAY? Or take the most sensible way out and recommend that they go back to the Dr. for a clarification of what he wants. There is an ophthalmic preparation available and it would certainly simplify matters if he were allowed to prescribe it) I would favor having only ophthalmic drops and ointments allowed in the sections dealing with the use of drugs.



March 25, 1983

Mr. Harry Treager, Director
Ms. Wanda Fleming, Licensing Examiner
Department of Commerce & Economic Development
Division of Occupational Licensing
Pouch D
Juneau, Alaska 99811

Dear Mr. Treager & Ms. Fleming:

I'm writing to you in regard to the teleconference call of March 22, 1983.

After a discussion with the legislative committee of the Alaska Optometric Association, I realized that I had erred in my recommendations in regard to HB225. I had assumed that all sections of the bill were changes in the optometry law whereas Section 08.64.360 is part of the state medical law.

I had recommended changing the first three lines of that section. Inasmuch as HB225 is amending the current medical law, Section 08.64.360, and that I am in agreement with the amendment, I am retracting the recommendation I gave during the teleconference call.

I discussed this with Doctors Falconer and O'Connell individually by phone yesterday and they agreed that a retraction is in order. Thus, our only recommendation on HB225 is that endorsement be obtained by examination.

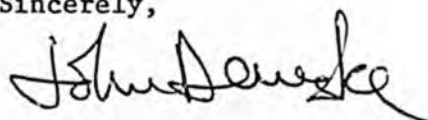
Since the teleconference, an identical bill has been introduced in the Senate as SB189. We would appreciate your submitting our recommendation to the Health, Education and Social Services committees of both the House and the Senate.

Per your request, I have contacted Tom Eichorst, counsel for the American Optometric Association in St. Louis, Missouri, in regard to registration with the Drug Enforcement Administration (DEA). He informed me that he is not aware of any problems with DEA registration in states where optometrists use therapeutic drugs. At his suggestion, I called John Robinson, O.D., Secretary for the North Carolina Optometry Board. Dr. Robinson stated that the individual optometrist applies for the federal DEA number. The DEA then verifies the doctor's credentials with the Secretary of the State Board. The DEA number is then issued and printed on the doctor's prescription blanks. Dr. Robinson added that to date, they have not had any conflicts with the DEA or their Board of Pharmacy.

Mr. Harry Treager, Director
Ms. Wanda Fleming, Licensing Examiner
March 25, 1983
Page 2

I hope that this information is helpful to you. Mr. Eichorst mentioned that you could contact him directly if you had any further questions. He can be reached at (314) 991-4100.

Sincerely,

A handwritten signature in cursive script, appearing to read "John A. Demske".

JOHN A. DEMSKE, O.D.
Secretary, Board of Optometry

cc: Dr. Maynard Falconer
Dr. Robert O'Connell

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

April 15, 1983

*ackn + in letter
also thank for
phone call*

RECEIVED

APR 20 1983

Josephson.

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

Dear Senator Josephson:

re: SB 189

I would like to comment on testimony by three individuals who spoke in opposition to SB 189 at the HESS Committee hearing on April 13, at which I was in attendance.

1. Representative Milo Fritz said there was no such thing as a "legend drug", though he claimed to be knowledgeable in matters of medicine. "Legend" is a well known term applied to certain drugs, also known as prescription or ethical drugs, which can legally be dispensed only on written prescription of a physician, dentist or podiatrist. This is in contradistinction to over-the-counter drugs, also known as non-prescription or proprietary drugs.

2. The testimony of Mr. Harry Treager, Director of the Division of Occupational Licensing, contained several statements and opinions that appeared to be outside the expertise or purview of an agency charged with providing administrative support for the examining and licensing functions carried out by occupational licensing boards. Even within his purview, there was a substantial inaccuracy: Mr. Treager stated, in answer to a question from you, that if the bill were passed, it would be necessary to add another employee to the Division to handle the assignment of DEA numbers from the federal Drug Enforcement Administration to individual optometrists. In point of fact, any doctor who desires a DEA number applies for it directly to the Drug Enforcement Administration. There is no involvement by any state licensing agency. Mr. Treager also stated that passage of the bill would increase the workload of the Division by requiring the optometry board to research the educational programs of optometric institutions. In fact, the determination of the data gathering method and the subsequent analysis of technical data would be performed by the board itself; any public input from interested groups that might be deemed necessary under the Administrative Procedures Act can be solicited by letter, and at most, one public hearing would be necessary, in conjunction with a regular board meeting. In relation to the Division's total workload, such increase would be insignificant, and in any event, the board could seek such support services on a

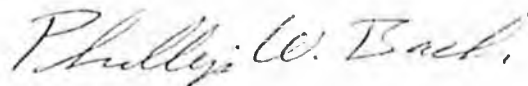
*I may have covered
A. Stated you I returned
house about you
over to Senate. I
understand that
this may not occur
and wonder what
purpose we should
pursue at this*

cost free basis from an interested group such as the Alaska Optometric Association. Mr. Treager appears to display a personal antipathy toward the bill, and I expect that he will attempt to attach a fiscal note to cause the bill to be referred to the Finance Committee. The Department of Health and Social Services attached a fiscal note to a similar bill, CSSB 136, in the Twelfth Alaska Legislature. Then, as now, Sen. Don Bennett was Co-Chairman of the Finance Committee. Senator Bennett was and is employed by a medical clinic on which staff are ophthalmologists. Senator Bennett would not agree to consider the bill without revisions unacceptable to optometry. A similar situation could be expected to obtain should the bill again be referred to the Finance Committee.

3. David Spence, MD, of the Department of Health and Social Services, proposed stricter and more specific requirements for certification in drug usage than those provided for in the bill, "to insure protection of the public". While it is appropriate that his department provide input regarding health legislation, his testimony failed to indicate why such presumed safeguards are needed for optometry but not for dentistry. Dr. Spence also advocated joint promulgation of regulations by the optometry and medical boards. However any such arrangement that would give the medical board effective veto power over the regulations is considered unacceptable to optometry, because when this has been tried in other states (e.g. Montana and Texas), the medical board has either failed to act or has set standards that are inconsistent with those required for the other autonomous prescribing professions of medicine, dentistry and podiatry.

Also in regard to Dr. Spence's suggestions, I would note that the evolving body of case law contains a court decision declaring unconstitutional a provision of licensing law restricting the kinds of similar surgical operations that podiatrists are allowed to perform. Some legal authorities believe this case may be applicable to other fields, including optometry, where, for instance, exclusion from optometric use of all but a few diagnostic drugs may be impermissible in the absence of clearly demonstrated benefits to the public safety and welfare. A copy of this analysis is attached. In the same connection, I have also attached a letter dated March 3, 1981 from Dean Thomas L. Lewis, of Pennsylvania College of Optometry, outlining the classes of drugs currently taught at that institution. I also notice his use of the term, "legend drugs", on page 3.

Very truly yours,



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

PWB/lr

Attachments: 2

State court stomps on licensing provision

For several years it has appeared that, even though private sector certifying agencies were legally vulnerable to antitrust attack, state licensing agencies and boards were sturdily protected. In December 1981, however, a circuit court in Montgomery, AL, struck down a state licensing scheme that set limits on the scope of practice of a health profession.

At issue in the case, captioned *Wood v. Graddick*, was a portion of the state licensing law for podiatry that prohibited podiatrists from working on the tarsals of the human foot. The law allowed them to work with all other parts of the foot, but reserved the tarsals to the jurisdiction of the medical profession.

That distinction, said the court, is malodorous. The court found no reason why podiatrists could be considered competent enough to operate on the metatarsals and phalanges, but not the tarsals. The court's opinion noted that the law effectively keeps many podiatrists out of Alabama. And, comparing podiatric education favorably to medical training, the court found:

... it appears that podiatrists are better qualified than osteopaths and MDs, by education training, and experience, to treat the tarsals, and are at least as well qualified as orthopedists, who comprise only 5 percent of the medical doctor population.

What is significant about the case is its use of a legal theory seldom applied to occupational licensure. The 14th Amendment to the U.S. Constitution—the same amendment that mandates states to provide “due process of law”—also mandates them to afford “equal protection of the laws” to everyone. Distinctions in laws or regulations that establish two classes of persons and treat them differently must be rationally related to a legitimate state purpose.

In the *Wood* case the two classes were physicians and podiatrists. The former were permitted to operate on the tarsals, while the latter were not. Because the court found that this distinction bore no rational relationship to the state's legitimate purpose of protecting the public health, the court struck down the relevant provisions of

the podiatric licensing law.

Indeed, the court went so far as to say that, not only must all licensed podiatrists be permitted to operate on the tarsals, but also many medical doctors probably should be prohibited by law from performing surgical procedures on the tarsals:

... the classification scheme adopted by the legislature as it relates to the tarsal bones of the foot is both overinclusive—by including within the preferential class many medical doctors who are unqualified—and underinclusive because it excludes podiatrists who are qualified to perform surgery to the tarsal bones.

Currently, all licensed physicians enjoy unlimited licensure, with no bounds on their scope of practice, in all states. Here, the court suggests that some bounds should be applied as a matter of law. However, the court did not draw such bounds itself, granting only enough relief to permit licensed podiatrists to handle the tarsals.

We now may assume that further litigation will develop, across the country, to strike down arbitrary scope of practice limits in state licensing laws. The result could revolutionize licensure by requiring professions that receive preferential treatment under the laws to show that they are better qualified than other professions to perform the specific functions at issue. Clinical social workers prohibited from practicing psychotherapy, nurse practitioners and physician assistants banned from prescribing common drugs, nurse-midwives effectively denied hospital privileges as a matter of law, and optometrists, pharmacists, and the bevy of other professions with reasonable gripes about licensure could be favorably affected.

A few words of caution. Alabama was the only state maintaining this bizarre prohibition on podiatry. On issues where there is a reasonable division of opinion among states, the result could be very different. Also, this is a state trial court opinion only. It lacks the force of precedent that a higher state court or a federal court could provide. But it does suggest the availability of a remedy to occupational groups that are short-shrifted by legislatures in the enactment of licensure laws.

Supplement to Commission Reports
Vol. 3, No. 3, Summer 1982

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1101 30th Street, N.W. Washington, D.C. 20007



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

Office of Academic Affairs

**Pennsylvania College
of Optometry**

March 3, 1981

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

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

Dear Doctor Bach:

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

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

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

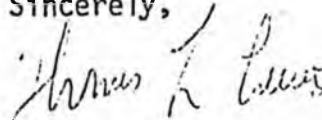
Listed below are the major classifications and categories of pharmaceutical agents commonly utilized in the patient care setting of the College. Examples are given of different drugs in each category. This is not to be interpreted that other drugs within these categories are not utilized when specifically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

- I. Topical Anesthetics
 - Example: Proparacaine
Benoxinate
- II. Mydriatics
 - A. Sympathomimetics
 - Example: Phenylephrine
 - B. Parasympatholytics
 - Example: Atropine group
- III. Cycloplegics
 - A. Parasympatholytics
 - Examples: Atropine group
Cyclopentolate
- IV. Miotics
 - A. Examples: Pilocarpine
Anticholinesterases
- V. Antimicrobials
 - A. Antibiotics
 - Examples: Tetracycline
Erythromycin
Gentamicin
Chloramphenicol
Bacitracin
Cephalosporins
 - B. Antibacterial
 - Example: Sulfonamides
 - C. Antiviral
 - Example: Idoxuridine
 - D. Antifungal
 - Example: Natamycin
- VI. Anti-inflammatory
 - Example: Corticosteroids
- VII. Anti-glaucoma
 - A. Sympathomimetics
 - Example: Epinephrine
 - B. Sympatholytic
 - Example: Timolol Maleate
 - C. Parasympathomimetics
 - Examples: Pilocarpine
Anticholinesterases
 - D. Carbonic Anhydrase Inhibitors
 - Example: Acetazolamide

- VIII. Antihistamines
Examples: Diphenhydramine
Antazoline
- IX. Miscellaneous Legend Drugs
Example: Hyperosmotic Agents
- X. Over-the-counter Drugs
Example: Dyes
Ocular Lubricants
Decongestants

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

Sincerely,



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

TLL:dmf

WEST VIRGINIA BOARD OF OPTOMETRY

JOHN E. CASTO, O.D.

SECRETARY-TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY

511 SIXTH AVE.

P.O. BOX 710

ST. ALBANS, W.VA. 25177



February 27, 1981

The Honorable Warren R. McGraw
President, Senate of West Virginia
State Capitol Building
Charleston, West Virginia 25305

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

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

Dear President McGraw and Speaker See:

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

Recent information compiled from the one hundred thirty-five (135) West Virginia registered optometrists now certified by this Board for drug usage is as follows:

1. A total of seventy-two (72) different drugs prescribable for the human eye have been employed by these West Virginia certified optometrists since the law was enacted.
2. Forty-seven thousand one hundred twenty-one (47,121) individual patients have been seen by these optometrists and conditions such as infectious or allergic conjunctivitis, corneal abrasions and blepharitis (granulated eye lids) have been treated by those certified in the compilation.
3. The distance those patients, who otherwise would have had to travel to geographical locations other than those of the treating optometrists for treatment by ophthalmologists or appropriate medical specialists to whom they formerly were referred, would have had to travel would have required that over 620,000 aggregate miles be traveled by the 47, 121 patients.

The Honorable Warren R. McGraw
The Honorable Clyde M. See, Jr.
February 27, 1981
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4. Fifty-two (52) different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

These 135 West Virginia optometrists who have been certified in every county of the state are now, faithfully and well, providing updated eye health care benefits to the people of West Virginia.

It should be additionally noted that there has been no report to this Board of any adverse reaction in the diagnosis and treatment rendered to patients involved by any West Virginia certified optometrist.

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

Sincerely yours,

John E. Casto, O.D.

John E. Casto, O.D.
Secretary-Treasurer

JEC/scp

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
POSITION PAPER
SB 189/HB 225

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

The above-cited legislative bills are the same in wording, intent, and subject matter.

The Department of Commerce and Economic Development opposes this legislation for the following reasons:

1. This legislation does not protect the public. There is no identified public support or hue and cry for the passage of this legislation.
2. It provides broad prescriptive authority for controlled substances (drugs) without verification of the practitioners' ability.
3. The use of the term "legend drugs" is too broad for the number of drugs that are normally used in the treatment of eye and eyelid conditions.


"Legend drugs" according to this bill are "drugs whose containers must bear a label prohibiting dispensing without a prescription." This is a useless definition.

4. The Department of Health and Social Services has testified against the bill.


This legislation is a State sanction for the use of all legend drugs by a professional group not educated in their use, or results and effects of the broad spectrum use. It does not afford the public protection necessary in prescribing and distributing control substances.

The bill, in its present form, must be opposed as being too broad in the wide use of the terms "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." Section AS 08.72.300 does not sufficiently identify the drugs. The term "legend" is too broad and all encompassing.

The bill lacks public protection that should be a must when mandating the authorization of drug prescription and distribution.



Harry D. Treager, Director
Division of Occupational Licensing

 5/2/83

Richard A. Lyon, Commissioner

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

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

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

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

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

ABNORMALITIES OF VISION:

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

ABNORMALITIES OF TISSUE:

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

ABNORMALITIES OF MOTOR FUNCTION:

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

OTHER:

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

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

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

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

This act shall take effect immediately.

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

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

Case #1

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

Case #2

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

Case #3

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

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

Case #4

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

Case #5

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

Cases #6,7,8,9

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

Case #10

This is the well known Timothy Steele case. This child was seen by an optometrist in Fairbanks because his eyes were crossing. A dilating eye drop was used to dilate the child's eyes. The optometrist's record noted "No good reflex" in Timothy's right eye. He diagnosed Timothy's eye condition as accommodative esotropia, which is correctable by eyeglasses. He wrote a prescription for eyeglasses and made an appointment for Timothy to return to the clinic on January 29, 1974, for a checkup.

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

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

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

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

Recognizing the seriousness of the case, Dr. Wolf called in William Kinn, M. D., as a consultant. On July 9, 1974, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a subretinal mass. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. Concluding that specific tests were necessary to identify the disease, Timothy was flown to Letterman Army Medical Center where he was examined on July 12, 1974.

At Letterman, it was determined that, because of the danger of retinoblastoma, a fast-spreading, life-threatening malignancy, Timothy's eye should be removed. With parental consent, the surgery

was performed by Major Bradley C. Black, M. D.

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

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

Dr. Black was also aware of several cases where inflammation of the eye was treated with steroids, and in isolated cases steroid treatment has decreased the inflammation, resulting in minimal scarring. But in Dr. Black's opinion, in most instances toxocara is not seen by the ophthalmologist until it has been quite destructive. However, assuming that visual acuity in Timothy's right eye was 20/30 in December of 1973 and treatment with steroids was instituted, some vision might have been salvaged.

In Dr. Wolf's opinion, if Timothy had been seen by an ophthalmologist in 1973, very possibly the eye could have been saved. Since a granulomatous inflammation is a cellular reaction to a foreign object, treatment would be taken to block the reaction. Steroids are a recognized form of treatment for granulomatous inflammation.

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

"I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a 'judgement call' but a violation of the governing principles of professional standards.

Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.
DATED at Anchorage, Alaska, this 20th day of October, 1978."

ss: James M. Fitzgerald
United States District Judge