ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7075 HOUSE LABOR & COMMERCE

Pacific
CATARACT AND LASER INSTITUTE

TO: *Members of the Alaska Legislature*

FROM: *Robert O. Ford, MD*

DATE: *May 21, 1991*

Over the last ten years of working as an ophthalmologist closely with the optometric profession to provide eye care to the people of Washington, I have made some observations that I would like to share with you.

Relations between ophthalmology and optometry in general are unfortunately frequently dominated by competition and turf issues. Once I was able to get past that in my own thinking about eight years ago, I began to see things in a different light.

Individual and professional advancement is part of the American way. Optometry as a profession has grown progressively more sophisticated and capable. Unfortunately each step of the way, their efforts at self-improvement have been resisted by organized ophthalmology. The most frequent argument used has been that patients will suffer when practitioners practice beyond their training. It is true that patients will suffer if any practitioner overextends himself whether he be MD, OD, attorney, politician or anything else. The real issue of public safety lies with the morality, honesty, and faithfulness of each person using their own judgement to manage only things for which they are qualified, and to get consultation or make referrals when necessary.

My experience with optometry is that they are as a whole, above average in their commitment to providing quality care to their patients and requesting assistance or making referrals whenever a particular case is beyond their knowledge or training.

As I have observed the changes in Washington, first with an extension of optometry's freedom to use diagnostic drugs and then later with their freedom to use therapeutic drugs, I have not seen patients harmed. In fact the availability of eye care has improved, and I can recommend this course of action to the state of Alaska.

Sincerely,

Robert O. Ford

Robert O. Ford, MD
/de

2517 N E. Kresky
Chehalis, WA 98532
206 748-8622
1 800 868-9903

2302 Union Ave
Suite B-16
Tacoma, WA 98405
206 756-9440
1 800 888-9905

8203 W. Quinault Ave
Suite 200
Kennewick, WA 99336
509 736-0826
1 800 888-900

NORTH PACIFIC MEDICAL CENTER
104 CENTER AVE., SUITE 100
KODIAK, AK 99615

TELEPHONE (907) 486-4183

KEVIN CREELMAN, M.D.
GENERAL PRACTICE

LOREN HALTER, D. O. (D.A.B.F.P.)
RICHARD HOLYOKE, PA-C

March 6, 1992

TO: Members of the Alaska Legislature

FROM: Loren D. Halter, D.O.

RE: Senate Bill #157, Use of Pharmaceutical Agents by Optometrists

Dear Legislators:

I am writing this letter to support Senate Bill 157 especially for optometrists in general.

I am a family practitioner and have bene in Kodiak for the last 14 years. Dr. John Shank, O.D. has been the optometrist in my office for the past ten years. On numerous occasions I refer patients to Dr. Shank for evaluation and treatment. Also, I use Dr. Shank for hospital consultations on patients with eye problems.

Why optometrists have not had this use of pharmaceutical agents for eye treatments is beyond my wildest imagination. The optometrists are partners in the health care system and should now be included in this system instead of being on the outside looking in.

Therefore, I highly support this Senate Bill 157 and believe we should not withhold the medical treatment and the use of drugs from the optometrists any longer. As a profession, they have proven their worth beyond a shadow of a doubt and it is high time we get into the 21st century and let them do their thing as they have been doing for the past several years.

Therefore, please add my support to the passage of Bill 157 as I think the optometrists in Kodiak and the state of Alaska do an excellent job. Now is the time to take our blinders off and let the optometrists have all the tools to treat their patients in a much better manner.

If you have any further questions please do not hesitate to call or write to the above address.

Sincerely,

Loren D Halter DO

Loren D. Halter, D.O. (D.A.B.F.P.)
North Pacific Medical Center

LDH:re

M. Marcell Jackson, M.D.
A PROFESSIONAL CORPORATION

February 7, 1992

Donald Lehmann, M.D.
Alaska State Medical Association
Legislative Committee Chair
700 Katlian Street, Suite E
Sitka, AK 99835

Dear Dr. Lehmann:

As a family practice physician, I have become familiar with the scope of training and capability of Alaska licensed optometrists.

I support the updating of the Alaska optometry law to allow qualified optometrists to use therapeutic pharmaceutical agents limited to eye treatment.

Nationally, the American Public Health Association has passed a resolution supporting this legislation, and 29 states currently allow optometrists to use therapeutic drugs for the benefit of their patients.

I would request that the Alaska State Medical Association Legislative Committee support this legislation.

Sincerely,

M. Marcell Jackson, M.D.

2211 EAST NORTHERN LIGHTS BOULEVARD SUITE 207 ANCHORAGE, ALASKA 99508-4184
TELEPHONE 279-2531

MEDICAL PARK FAMILY CARE, Inc.
"Prompt, Thorough, Concerned"

F. LELAND JONES, M.D.
KENNETH S. LAUFER, M.D.
R. MATISON WHITE JR., M.D.
RICHARD R. TAYLOR JR., M.D.
CHARLES AARONS, M.D.
MARK NEWMAN, M.D.
ILONA JEAN HODSON, M.D.
ROBERT K. THORNQUIST, M.D.
Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BLVD., ANCHORAGE, ALASKA 99508 • (907) 279-8486 • FAX (907) 278-7255

February 12, 1992

Donald Lehmann, M.D.
Alaska State Medical Association
Legislative Committee Chair
700 Katlian Street, Suite E
Sitka, AK 99835

Dear Dr. Lehmann:

As a family practitioner, I have become familiar with the capability of Alaska licensed optometrists.

I support the updating of the Alaska optometry law to allow qualified optometrists to use therapeutic pharmaceutical agents limited to eye treatment. The expansion of clinical privileges of optometrists has been shown to increase the availability, accessibility, and cost effectiveness of eye care to the public.

In 1990 the American Public Health Association passed a resolution supporting this legislation, and 30 states currently allow optometrists to use therapeutic drugs for the benefit of their patients.

I would request that the Alaska State Medical Association Legislative Committee support this legislation.

Sincerely,

F. Leland Jones, M.D.

LAURANCE A. MARSHBURN, M.D.
ANESTHESIOLOGY
P.O. BOX 277
HOMER, ALASKA 99603
TELEPHONE (907) 235-7978

February 11, 1992

Don Lehmann, M. D.
Chairman, Legislative Committee
Alaska State Medical Society
700 Katlian Drive, Suite E
Sitka, AK 99835

Dear Dr. Lehmann:

I wish to go on record as supporting Senate Bill No. 15, relating to the change allowing the use of certain types of pharmaceuticals by properly trained and licensed optometrists as well as allowing the removal of superficial foreign bodies.

My background includes a thirteen year period of general practice, most of this in rural Alaska. I feel that frequently optometrists are truly the most knowledgeable person to diagnose and great eye disease in most rural communities. Outside of the urban areas, there are simply not enough ophthalmologists to care for the need. Optometrists, as a group and with proper training, should be viewed as a medical resource which can more effectively meet the needs of the population of rural Alaska.

Again, I would support the proposals of Senate Bill No. 157 and would urge that the ASMA Legislative Committee consider it favorably.

Very truly yours,

L. A. Marshburn, M. D.

Kachemak Bay Medical Clinic
Professional Corporation
PAUL D. RAYMOND M.D.
4285 Hohe St., Suite 2
Homer, Alaska 99603
(907) 235-4050

May 2, 1991

Dear Legislator:

I am writing this letter in support of Senate Bill 157, which involves the use of pharmaceutical agents by optometrists. As a family practitioner in a rural area of Alaska, without the presence of ophthamologists we depend greatly on qualified optometrists for evaluation and treatment of superficial and anterior chamber eye disease. This would include administrating topical steroids, antibiotics and antiglaucoma agents to the human eye. Obviously, this would be inherent on the licensee having been endorased under AS 08.72.175.

The ability of appropriately trained optometrists to diagnose and treat anterior chamber and superficial eye disease would prove beneficial not only for rural physicians but also would serve in the patients' best interests concerning long term cost containment. In my experience the optometrists in the geographical area in which I practice appropriately refer ophthamologic patients to board certified ophthamologists when indicated.

I appreciate your support.

Sincerely,

Paul D Raymond MD

Paul D. Raymond, M. D.

PDR:nmc
cc: Boyd Walker

Box 869
Homer, Alaska 99603
April 23, 1990

Senator Paul Fischer
Alaska State Legislature
Juneau, AK

Dear Senator Fisher,

I am writting to ask you to please do your best to get senate bill SCSNB222 - scheduled for debate and vote. I support Board certified optometrists prescribing anti infective and anti inflammatories, topically. Thanks for your support

Sincerely,

Hal Smith M.D

Hal Smith M.D

April 5, 1991

Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Legislator:

I am writing in support of Senate Bill 157 (Optometry Pharmaceuticals). I am glad to hear Alaska is currently addressing the issue of optometrists being allowed to prescribe a variety of therapeutic agents.

This action is long overdue and has already been approved in 26 other states.

I am a Colonel in the Air Force, a board certified Family Physician and Chief of the Emergency Room, Family Practice, and Primary Care Department at Elmendorf Air Force Base Regional Hospital. I have thus had frequent professional exposure to optometrists and thus feel I can speak quite objectively.

I feel optometrists are fully qualified to expand their prescribing service to their patients.

I would hope an objective review of this issue be undertaken and passage of the bill be the outcome.

Sincerely,

Richard M. Stratton

Richard M. Stratton, M.D., Colonel, USAF, MC

2420 Banbury Drive
Anchorage, AK 99504

MEDICAL PARK FAMILY CARE, Inc.
"Prompt, Thorough, Concerned"

F. LELAND JONES, M.D.
KENNETH S. LAUFER, M.D.
R. MATISON WHITE JR., M.D.
RICHARD R. TAYLOR JR., M.D.
CHARLES AARONS, M.D.
MARK NEWMAN, M.D.
ILONA JEAN HODSON, M.D.
ROBERT K. THORNQUIST, M.D.
Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BLVD., ANCHORAGE, ALASKA 99508 • (907) 279-8486 • FAX (907) 278-7255

February 12, 1992

Donald Lehmann, M.D.
Alaska State Medical Association
Legislative Committee Chair
700 Katlian Street, Suite E
Sitka, AK 99335

Dear Dr. Lehmann:

As a family practitioner, I have become familiar with the capability of Alaska licensed optometrists.

I support the updating of the Alaska optometry law to allow qualified optometrists to use therapeutic pharmaceutical agents limited to eye treatment. The expansion of clinical privileges of optometrists has been shown to increase the availability, accessibility, and cost effectiveness of eye care to the public.

In 1990 the American Public Health Association passed a resolution supporting this legislation, and 30 states currently allow optometrists to use therapeutic drugs for the benefit of their patients.

I would request that the Alaska State Medical Association Legislative Committee support this legislation.

Sincerely,

R. Taylor

Richard R. Taylor, M.D.

April 8, 1991

Alaska Legislature
Juneau, AK

Dear Legislators,

We are writing this letter to inform you that we support the bill in legislation that will allow Optometrists to prescribe medications for the treatment of eye disease.

I was previously a patient of Ed Craig, O.D. who practiced in our community for many years. In fact it was he who first detected my glaucoma in 1985 and referred me to an ophthalmologist in Seattle for treatment. My health is not as good as it once was and I find it impossible to travel to Seattle for my follow-up visits. Dr. Eric Christiansen has taken over Dr. Craig's practice and has been following the status of my the glaucoma for a year. I feel comfortable with his care and follow-up. I had a bad experience with the ophthalmologists that travel to our city periodically and do not wish to see them for care. It frustrates my husband and I when we cannot get a prescription for eye drops renewed or changed during a follow-up visit at Dr. Christiansen's office. The doctor must call the ophthalmologist in Seattle and have him call my prescription to a pharmacy in Ketchikan. Dr. Christiansen has told us the ophthalmologist in Seattle is uncomfortable with this arrangement due to my inablility to travel to Seattle for follow-up. Optometrist's are available any time because they live here. If their education trains them to understand the prescription of medications for treatment of eye disease then they should be allowed to prescribe it. It would save Alaskan's with eye problems time, money, and frustration. It would also improve our ability to obtain treatment immeadiately if we need it. Please consider passing this important legislation. Thank you.

Regards,

Ruth Terwilliger

Ruth Terwilliger

Ruth A. and Wesley B. Terwilliger
Marine View, Apt. 509
Ketchikan, AK 99901

ANPA

Alaska Nurse Practitioner Association

February 24, 1992

Subject: SB 157 Qualified optometrists to prescribe limited therapeutic pharmacologic agents for treatment of primary eye diseases.

Dear Legislator:

It is the position of the Alaska Nurse Practitioner Association to support the efforts of the Alaska Optometric Association to obtain limited therapeutic pharmacologic prescriptive authority. The ability to diagnosis and treat common eye problems will be evident in the decreased cost for long term problems related to untreated eye problems.

Often, the optometrist is the only eye specialist travelling to the bush areas. Without the ability to treat the common eye problems seen in the bush, patients would have to pay travel costs to a regional center instead of being treated in the village. The expediency of treatment lowers the costs to both the patients and the state. Untreated eye conditions can develop into more costly long term conditions requiring travel to a larger medical center and specialized treatment.

We hope you will join us in support of SB 157

Sincerely,

Wendy Thoa, ANP
Alaska Nurse Practitioner Association
Secretary

Fairbanks Clinic
Quality Care Since 1932

April 23, 1991

Alaska State Legislature
PO Box V
Juneau, Alaska 99811

Dear Sirs:

I am writing this letter in support of Senate Bill 157 concerning optometry prescribing privileges.

I was on active duty as a medical officer in the United States Air Force from 1981-1988. During the last five years of that time I was assigned to the USAF clinic at Eielson Air Force Base. Part of my duties there was to serve as direct supervisor for the optometrists. During that period of supervision, the Air Force changed its prescribing rules and began to allow optometrists with appropriate training to prescribe certain classes of medication. In order to obtain these prescribing privileges, the optometrist had to show documented proof of ocular therapeutics training during his original professional schooling or evidence of adequate education in ocular therapeutic since graduation from optometry school. With documentation of the appropriate training, these optometrists were then permitted to prescribe medications in classes similar to those mentioned in Senate Bill 157.

I have had the opportunity to work with several optometrists who have been credentialed under these rules and have found that they have been able to provide increased service to their patients. I have not seen any significant problems associated with optometrist-prescribing practices.

I feel that it would be a benefit to the residents of Alaska to permit optometrists to prescribe those medications noted in Senate Bill 157. I believe that appropriately trained optometrists are capable of effectively and safely treating relatively minor eye problems with medications, as specified in Senate Bill 157, and therefore am in favor of passage of this bill.

Sincerely,

Enlow R. Walker, M.D.
Family Practice

ERW/hlb

1867 Airport Way • Fairbanks, Alaska 99701
(907) 452-1761

STATE	DIAGNOSTIC USE	THERAPEUTIC USE
ALABAMA	*	
ALASKA	May 25, 1988	
ARIZONA	April 25, 1980	
ARKANSAS	April 2, 1979	March 3, 1987
CALIFORNIA	July 9, 1976	
COLORADO	June 10, 1983	April 20, 1988
CONNECTICUT	April 2, 1986	
DELAWARE	July 10, 1975	
D.C.	March 25, 1986	
FLORIDA	July 10, 1986**	July 10, 1986**
GEORGIA	February 14, 1980	February 25, 1988
GUAM	December 28, 1982	
HAWAII	June 12, 1985	
IDAHO	March 23, 1981	March 31, 1987
ILLINOIS	September 15, 1984	
INDIANA	***	***
IOWA	June 8, 1979	May 31, 1985
KANSAS	April 12, 1977 (2:00 p.m.)	April 17, 1987
KENTUCKY	March 29, 1978	February 7, 1986
LOUISIANA	July 6, 1975	
MAINE	June 24, 1975	June 25, 1987
MARYLAND	January 13, 1989	
MASSACHUSETTS	December 23, 1985	
MICHIGAN	March 26, 1984	
MINNESOTA	March 8, 1982	
MISSISSIPPI	March 17, 1982	
MISSOURI	July 24, 1981	June 24, 1986
MONTANA	April 12, 1977 (10:10 a.m.)	April 23, 1987
NEBRASKA	February 13, 1979	March 26, 1986
NEVADA	May 25, 1979	
NEW HAMPSHIRE	June 6, 1985	
NEW JERSEY	*	January 16, 1992
NEW MEXICO	March 4, 1977	April 5, 1985
NEW YORK	July 15, 1983	
NORTH CAROLINA	June 3, 1977	June 3, 1977
NORTH DAKOTA	March 22, 1979	April 10, 1987
OHIO	March 15, 1984	February 15, 1992
OKLAHOMA	April 6, 1981	March 22, 1984
OREGON	May 20, 1975	August 9, 1991
PENNSYLVANIA	March 1, 1974	
RHODE ISLAND	July 16, 1971	June 26, 1985
SOUTH CAROLINA	March 21, 1984	
SOUTH DAKOTA	March 15, 1979	March 15, 1986
TENNESSEE	May 8, 1975	April 22, 1987
TEXAS	August 5, 1981	June 15, 1991
UTAH	March 21, 1979	March 20, 1991
VERMONT	April 23, 1984	
VIRGINIA	February 25, 1983	April 11, 1988
WASHINGTON	April 23, 1981	April 18, 1989
WEST VIRGINIA	March 4, 1976	March 4, 1976
WISCONSIN	April 29, 1978	August 3, 1989
WYOMING	February 17, 1977	March 2, 1987

FOOTNOTE KEY:

** = General legislation, favorable attorney general opinion.*

*** = Previous favorable attorney general opinion. Specific legislation enacted in 1986.*

**** = General legislation, favorable attorney general opinion. Legislation which would have prohibited pharmaceutical utilization defeated. Appeal from dismissal of litigation which would have prohibited pharmaceutical utilization denied by state supreme court, February 27, 1986. Clarification legislation adopted May 13, 1991.*

HRS STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

April 23, 1990

Carmin A. Guida
Executive Director
Massachusetts Society of Optometry
101 Tremont Street
Boston, Massachusetts 02108

Dear Dr. Guida:

In response to your inquiry concerning Florida's experience with optometrists having the ability to dispense non-controlled substance drugs to Medicaid recipients, I would have to state my feeling that overall it has been quite successful from several points of view.

- Ability of recipients to access medical care.

Unfortunately in Florida, provider participation among ophthalmologists is low. Many of the ophthalmologists who do participate in the Medicaid program are in the larger metropolitan areas. This leaves vast areas of the state where the only eye care services available are provided by optometrists. By giving optometrists the ability to prescribe certain drugs, we greatly improved the recipient's access to medical care.

- Decrease in transportation costs.

Florida Medicaid does pay for a recipient's transportation costs to obtain medical services. If a recipient was unable to receive the necessary treatment from an optometrist, the state would pay to transport a recipient to an area where there was an ophthalmologist who agreed to accept the recipient. However, there could be time delays waiting for a recipient to get an appointment, thereby limiting the timeliness of the needed medical care.

- Duplicative office visits eliminated.

In our experience, prior to optometrists being able to dispense certain drugs, it was possible to pay for one office visit to the optometrist and then a second visit either to an ophthalmologist or a general physician to obtain the required medication. This caused not only delays where the medical problem would at times go without

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

STATE	DIAGNOSTIC USE	THERAPEUTIC USE
ALABAMA	*	
ALASKA	May 25, 1988	
ARIZONA	April 25, 1980	
ARKANSAS	April 2, 1979	March 3, 1987
CALIFORNIA	July 9, 1976	
COLORADO	June 10, 1983	April 20, 1988
CONNECTICUT	April 2, 1986	
DELAWARE	July 10, 1975	
D.C.	March 25, 1986	
FLORIDA	July 10, 1986**	July 10, 1986**
GEORGIA	February 14, 1980	February 25, 1988
GUAM	December 28, 1982	
HAWAII	June 12, 1985	
IDAHO	March 23, 1981	March 31, 1987
ILLINOIS	September 15, 1984	
INDIANA	***	***
IOWA	June 8, 1979	May 31, 1985
KANSAS	April 12, 1977 (2:00 p.m.)	April 17, 1987
KENTUCKY	March 29, 1978	February 7, 1986
LOUISIANA	July 6, 1975	
MAINE	June 24, 1975	June 25, 1987
MARYLAND	January 13, 1989	
MASSACHUSETTS	December 23, 1985	
MICHIGAN	March 26, 1984	
MINNESOTA	March 8, 1982	
MISSISSIPPI	March 17, 1982	
MISSOURI	July 24, 1981	June 24, 1986
MONTANA	April 12, 1977 (10:10 a.m.)	April 23, 1987
NEBRASKA	February 13, 1979	March 26, 1986
NEVADA	May 25, 1979	
NEW HAMPSHIRE	June 6, 1985	
NEW JERSEY	*	January 16, 1992
NEW MEXICO	March 4, 1977	April 5, 1985
NEW YORK	July 15, 1983	
NORTH CAROLINA	June 3, 1977	June 3, 1977
NORTH DAKOTA	March 22, 1979	April 10, 1987
OHIO	March 15, 1984	February 15, 1992
OKLAHOMA	April 6, 1981	March 22, 1984
OREGON	May 20, 1975	August 9, 1991
PENNSYLVANIA	March 1, 1974	
RHODE ISLAND	July 16, 1971	June 26, 1985
SOUTH CAROLINA	March 21, 1984	
SOUTH DAKOTA	March 15, 1979	March 15, 1986
TENNESSEE	May 8, 1975	April 22, 1987
TEXAS	August 5, 1981	June 15, 1991
UTAH	March 21, 1979	March 20, 1991
VERMONT	April 23, 1984	
VIRGINIA	February 25, 1983	April 11, 1988
WASHINGTON	April 23, 1981	April 18, 1989
WEST VIRGINIA	March 4, 1976	March 4, 1976
WISCONSIN	April 29, 1978	August 3, 1989
WYOMING	February 17, 1977	March 2, 1987

FOOTNOTE KEY:

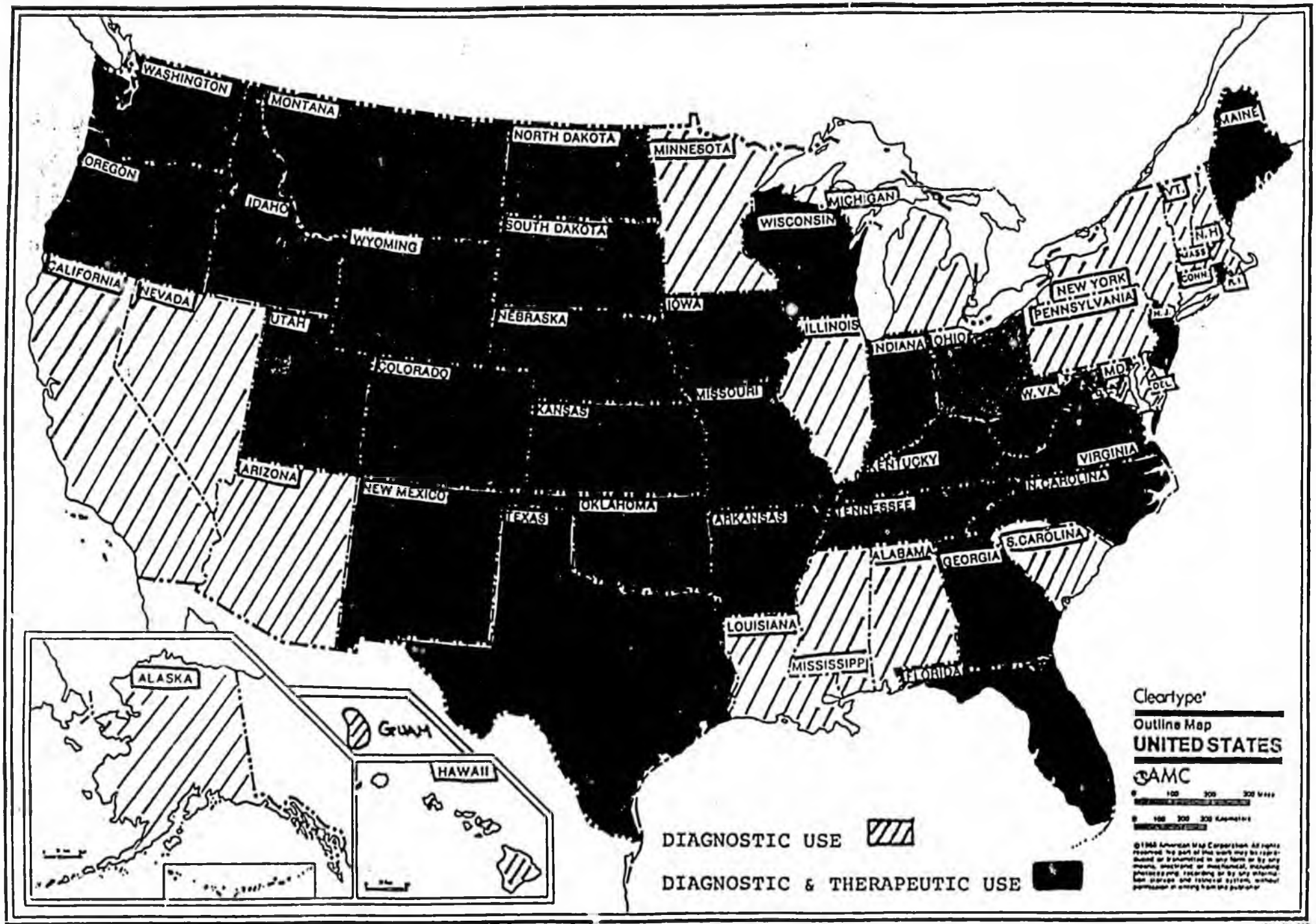
** = General legislation, favorable attorney general opinion.*

*** = Previous favorable attorney general opinion. Specific legislation enacted in 1986.*

**** = General legislation, favorable attorney general opinion. Legislation which would have prohibited pharmaceutical utilization defeated. Appeal from dismissal of litigation which would have prohibited pharmaceutical utilization denied by state supreme court, February 27, 1986. Clarification legislation adopted May 13, 1991.*

STATUS OF PHARMACEUTICAL LEGISLATION

February
~~January~~ 16, 1992



April 23, 1990

Carmin A. Guida
Executive Director
Massachusetts Society of Optometry
101 Tremont Street
Boston, Massachusetts 02108

Dear Dr. Guida:

In response to your inquiry concerning Florida's experience with optometrists having the ability to dispense non-controlled substance drugs to Medicaid recipients, I would have to state my feeling that overall it has been quite successful from several points of view.

- Ability of recipients to access medical care.

Unfortunately in Florida, provider participation among ophthalmologists is low. Many of the ophthalmologists who do participate in the Medicaid program are in the larger metropolitan areas. This leaves vast areas of the state where the only eye care services available are provided by optometrists. By giving optometrists the ability to prescribe certain drugs, we greatly improved the recipient's access to medical care.

- Decrease in transportation costs.

Florida Medicaid does pay for a recipient's transportation costs to obtain medical services. If a recipient was unable to receive the necessary treatment from an optometrist, the state would pay to transport a recipient to an area where there was an ophthalmologist who agreed to accept the recipient. However, there could be time delays waiting for a recipient to get an appointment, thereby limiting the timeliness of the needed medical care.

- Duplicative office visits eliminated.

In our experience, prior to optometrists being able to dispense certain drugs, it was possible to pay for one office visit to the optometrist and then a second visit either to an ophthalmologist or a general physician to obtain the required medication. This caused not only delays where the medical problem would at times go without

In summary, I want to point out that in Florida we have a large, politically active elderly population. It was in the best interests of both the health care system as a whole, and the population in need of quality medical eye care to have a law permitting optometrists to fully participate in the treatment of the individuals under their care.

In response to your request concerning costs, I regret that I am unable to give you data that shows the number of prescriptions by various provider groups. When the law in our state was under consideration, we anticipated an increase in prescriptions. Opponents argued it would remain the same, as different providers would be prescribing the drugs. My feeling, which is not based on any concrete data, is that yes, prescriptions have increased for eye care related services, BUT our recipients under Medicaid are receiving services which they may not have otherwise received. This new access to medical care is the immeasurable success I believe to be the major result of this legislation which was based in our state.

For your comparison, Florida Medicaid currently has approximately 650,000 active Medicaid recipients on our files. While my experience has been in the public health area, the law has of course, has an effect on all of our citizens in the State of Florida.

For further information, I would like to refer you to our Florida Optometric Association, 401 Office Plaza Drive, Tallahassee, Florida 32301. Their office should be able to tell you specific data and/or information about the impact on the non-Medicaid population of our state.

I hope this information has been of some use to you. Please feel free to contact me at (904) 488-9347 if you have further questions.

Sincerely,

Wendy Johnston

Wendy Johnston
Program Administrator
Policy Development Unit

WLJ:ps

COMMONWEALTH OF KENTUCKY

BOARD OF OPTOMETRIC EXAMINERS

1000 W. MAIN STREET

GEORGETOWN, KENTUCKY 40324

863-8818
AREA CODE 502

April 24, 1989

Sen. Robert Ney
State House
Columbus, Ohio 43266-0604

Dear Sen. Ney:

I am happy to give you the following progress report since the passage of SB 104 which went into effect in Kentucky on July 15, 1986.

There has been no increase in complaints from the general public since the passage of this Bill, and there has not been any complaints dealing with the use of therapeutic drugs. Insurance rates for our optometrists have actually decrased. One of the main advantages of this legislation is that, due to the large amount of rural areas in Kentucky, the public has been saved countless numbers of miles and dollars.

When this Bill went into effect the board required each TPA certified O.D. to keep a drug log setting out specific information on each patient prescribed for. The following information was turned in to our office in December, 1987.

Number of Rx's written - 37,817
Number of patients prescribed for - 36,493
Number of conditions treated collectively - 2,158
Number of different conditions treated - 62
Miles saved - 843,368
Dollars saved - $1,115,086.00

I have enclosed a copy of SB 104 for your information. Please contact us if we can be of any help.

Sincerely yours,

John C Schertzinger

J. C. Schertzinger, O.D.
President

cc: Darlene Eakin
Earl K. Green

JCS/at

WEST VIRGINIA BOARD OF OPTOMETRY

DALE E. PALMER, O.D.
SECRETARY-TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY
POST OFFICE BOX 67
NUTTER FORT, WEST VIRGINIA 26301
(304) 624 5317

October 16, 1986

Dan J. Lex
P.O. Box 2186
Cheyenne, Wyoming 82003

Dear Mr. Lex:

This letter is in response to your inquiry of October 8, 1986, regarding the therapeutic drug experience. For the sake of brevity, I will answer each question by number:

(1) Law became effective March, 1976.

(2) Therapeutic alone would probably be in the neighborhood of 250,000 to 400,000. Combined with diagnostics, the number would be 1,300,000 based on 100 doctors using diagnostics on 1,200 patients per year. Therapeutic figure is conservative estimate of four cases per week, per doctor times 10 years. Actual numbers could double this.

(3) No cases of misuse of therapeutic drugs have been reported to our board, and no cases have come to court involving misuse of therapeutic drugs.

(4) Based on an average of $20.00 office visit for therapeutic patient verses average of $40.00 for ophthalmology, a savings of $5,000,000 to $8,000,000, and I would consider this conservative.

(5) The cost of malpractice insurance has not been adversely affected by therapeutic drug use at all.

Sincerely,

Dale E. Palmer

Dale E. Palmer, O.D.
Secretary-Treasurer

DEP:jj

VISION CLINIC, P.C.
Family Practice of Optometry

2628 BEAVER AVENUE
DES MOINES, IOWA 50310
515 274-4141

JAMES W. HARTZELL, O.D., F.A.A.O.
DONALD B. HENRY, O.D.

February 17, 1990

The Honorable Joseph Roberts
655 Creek Road
Bellmaur, NJ 08031

Dear Assemblyman Roberts:

I received a letter today from your constituent, Dr. Larry Wallis of the New Jersey Optometric Association. As you know, the New Jersey Optometric Association is currently supporting legislative efforts to expand the scope of the practice of Optometry in the State of New Jersey. Dr. Wallis asked if I would relate to you the current status and history of the use of ocular therapeutics in the State of Iowa.

Iowa currently has the broadest therapeutic pharmaceutical law in the United States. Our law was passed in 1985 and was expanded again in 1987 to include the use of oral and topical antibiotics, controlled substances, and oral and topical agents for the treatment of glaucoma by Iowa optometrists. I can report to you that to date, our experience with optometrists using therapeutic pharmaceutical agents has been good. No abuses or complaints have been reported and no malpractice claims have been filed. We have had to take no disciplinary action against any Iowa optometrists for misusing pharmaceutical agents, therapeutic or otherwise.

Thank you for taking time to read this letter supporting optometric therapeutic legislation in the State of New Jersey.

Sincerely,

James W. Hartzell, O.D.

James W. Hartzell, O.D., Chairperson
Iowa State Board of Optometry Examiners

JWH:shm

cc: Dr. Larry Wallis
88 Lakedale Drive
Trenton, New Jersey 08648

SOUTH Dakota

Department of Social Services
OFFICE OF PROGRAM MANAGEMENT

MEDICAL SERVICES
Richard F. Kneip Building
700 Governors Drive
Pierre, South Dakota 57501-2291

(605) 773-3495

December 21, 1988

Representative Timothy Ford
Speaker of the House
House of Representatives
State Capitol Building
Jackson, Mississippi 39201

Dear Representative Ford:

The State of South Dakota passed a law effective July 1, 1986 that allowed qualified optometrists to provide certain therapeutic services that had, in the past, only been provided by physicians.

Subsequent experience under the Medicaid program has not shown any increase in utilization rates as a result of this statute nor have we seen any increase in the average cost of services attributable to these services being provided by optometrists. We would say that the impact of the change in law governing the practice of optometry in South Dakota has been very small, if any.

Please contact our office if you have any questions or wish additional information.

Sincerely,

Ervin Schumacher
Administrator

ES:AF:bk

cc: Dr. Glenn Robeson

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION
DIVISION OF INSURANCE
280 FRIEND STREET, BOSTON 02114
(617) 727-7189

TIMOTHY H. GAILEY
COMMISSIONER OF INSURANCE

March 26, 1990

Senator John P. Houston
Representative Paul Kollios
Chairpersons, Committee on Human Services
and Elderly Affairs
State House, Room 22
Boston, MA 02133

Dear Senator Houston and Representative Kollios:

I am writing to support S. 612, "An Act Relative to Cost Effectiveness and Accessibility of Certain Human Services". The bill would expand the scope of practice of optometrists, consistent with regulations to be promulgated by the Board of Registration in Optometry.

An expansion of the permissible scope of optometric practice, subject to appropriate regulatory approval, could make a contribution to containing the rising cost of health care and health insurance premiums. The average cost of a visit to an optometrist is significantly less expensive than a visit to an opthamologist. Currently, there is a significant incidence of double visits for the treatment of certain eye diseases because many patients who initially visit optometrists must be referred to opthamologists for the administration of medication. In addition, many patients who now are forced to seek care in hospital emergency rooms in order to see an opthamologist could be treated much less expensively by community-based optometrists.

I urge the Committee to give S. 612 a favorable report.

Sincerely,

Timothy H. Gailey

Timothy H. Gailey
Commissioner of Insurance

0021N

NORTHWEST
EYE CENTER

State of the Art Technology
and Old Fashioned Care

February 8, 1989

State Senator Gary Nelson
106-A Inst. Building
Olympia, WA 98504

Dear Senator Nelson:

We are three ophthalmologists practicing in Seattle. We are writing in support of Senate Bill 5193, and feel that Doctors of Optometry should be allowed to use topical therapeutic drugs. We have had the opportunity and pleasure of sharing in the care of many patients with optometrists in your legislative district: Doctors Michael Medin and David Ross. These doctors provide excellent care. They have shown good judgment in their patient care decisions. We feel they will continue timely and proper care with therapeutic drug use. In the past two years we have participated in educational courses with these doctors. We have encountered a high level of interest and enthusiasm in these endeavors.

It is our hope that passage of this therapeutic bill will result in a greater unity between optometrists and ophthalmologists and ultimately our patients will be the beneficiaries.

If you have any questions or concerns, we would be happy to discuss them with you.

Yours very truly,

J. Stephen Brown, Jr., M.D.

Michael W. Field, M.D.

William E. Hancock, M.D.

J. Stephen Brown, Jr., M.D. | Michael W. Field, M.D. | William E. Hancock, M.D. | Brett G. Bence, O.D.
1560 North 115th Street, Suite 102 | Seattle, Washington 98133 | 206-365-7332 | 1-800-826-4631

Valley Eye and Laser Center

March 13, 1989

House of Representatives
Legislative Building, Room #
Olympia, Wa. 98504

Dear Representative

I am writing to express my strong support for Senate Bill #5193. I have been practicing medicine as an ophthalmolgist, specializing in eye disease and surgery for the past ten years.

I have reviewed the proposed change in Legislation carefully, and find it is a reasonable approach for expanding the scope of optometric practice. My experience with optometrists has shown me that they are very competent, careful, and ethical practitioners.

Please support this bill and move the issue out of the political arena, so all ophthalmologists and optometrists can get back to our main concern, the care of eyes.

Sincerely,

Paul N. Joos, M.D.

4011 Talbot Rd. S. #210, Renton, WA 98055 (206) 255-4250, 1-800-325-6498

AARP

NEVADA STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mr Gail Bishop
2700 West 7th Street
Reno, NV 89503
(702) 747-1814

VICE CHAIRMAN
Mr George M Lambert
155 East Cedar Street
Fernley, NV 89408
(702) 575-4876

SECRETARY
Mr Orland T Outland
2675 Valmar Place
Reno, NV 89503
(702) 747-3163

April 24, 1989

Senator Randolph J. Townsend
Nevada State Legislature
Capitol Complex
Carson City, NV 89710

re: S.B. 296

Dear Senator Townsend,

Under present circumstances, optometric patients sometimes must be referred from an optometrist to another provider just for the administration of ocular medication, resulting in an added expense for the patient for the added office visit.

The added office visit also results in an added expense attributable to the co-insurance payment for the separate visit.

People living on fixed, limited income could benefit by the passage of this bill by not being forced to undergo two office visits when one would suffice. Each visit entails a provider cost, but it also often entails extreme inconvenience for the elderly in arranging transportation for that added visit.

Very truly yours,

Gail Bishop
Chairman

YOU WILL HEAR

You have heard or will hear a number of reasons why the use of therapeutic drugs by optometrists is dangerous. Let me consider some of these.

YOU WILL HEAR that optometrists are not properly trained to use pharmaceuticals for therapy. This is simply not true. The course of study in this area is the same as that of medicine and more extensive than that of dentistry. Not only are the hours of pharmacology the same for medicine and optometry, but it should be noted that the medical student must study all organs equally, whereas, the optometry student can specialize in the eye once general pharmacology is completed. The drug interactions and systemic effects of the drugs administered for ocular conditions are studied in great detail. Students see numerous patients with pathology which requires pharmaceutical therapy. These students are supervised by ophthalmologists. So when other ophthalmologists say our students do not receive appropriate clinical instruction they are providing misinformation, by reacting emotionally not rationally.

YOU WILL HEAR that a profes[illegible]is non-medical should not be allowed to use drugs. Yet dentistry and podiatry are non-medical and use therapeutic drugs, and surgery in the course of their professional practice and no harm has come to the public. The real issue here is not whether optometrists are medical or non-medical; the fact is that optometrists are well trained health-care professionals.

YOU WILL HEAR that these therapeutic pharmaceutical agents can have systemic effects, effects on other parts of the body, and that there could be interactions with other drugs a patient may be taking. These are true statements and optometrists along with physicians, dentists, podiatrists and pharmacists study these areas and responsibly incorporate it into their practice. The information necessary for responsible use of these agents is in the public domain and accessible to all health professionals, not just to physicians. It was the result of scientific investigations and is not exclusively "medical".

YOU WILL HEAR that there will be public safety problems if optometrists are allowed to use these agents. Very unlikely situations and cases will be put forth, coupled with the assumption of absolutely no professional judgment on the part of the optometrist. These "strawmen" prove nothing. Yet, two states, West Virginia and North Carolina, have had this law for over 10 years and there have been no substantiated problems as a result. The reason I use the word substantiated is that there have been claims of problems but none that have been corroborated, and some have been found to be fraudulent. Twelve states have this law and the safety of the public is just fine. Better access, better quality care and cost containment have been the result.

In conclusion, optometry schools are educating and training optometry students well in the areas of diagnosis of eye pathology and in the responsible use of pharmacological agents. These students will graduate with the appropriate professional judgment to provide high quality eye care to their patients.

COMMENTS OF JOSEPH C. TOLAND, O.D., M.D., BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

My name is Joseph C. Toland. I graduated from the Pennsylvania College of Optometry with a Doctor of Optometry degree in 1954. Following five years of practice as an optometrists, including military service in the United States Air Force, I entered Hahnemann Medical School and graduated with the M.D. degree in 1963. I then undertook a three year residency in ophthalmology at Thomas Jefferson Medical School which was completed in 1967. I was Board Certified as an ophthalmologist in 1969.

I am currently an instructor in ophthalmology at the Thomas Jefferson Medical School and Professor of Pathology and Director of Ophthalmological Services at the Pennsylvania College of Optometry. In this capacity, I have intimate knowledge of the education of ophthalmology residents and optometry students.

I am here this morning to compare optometric and ophthalmologic education as it is related to the examination, diagnosis, treatment and management of ocular diseases of the primary care patient. With my background as an optometrist, I do not think there is anyone better qualified than myself to evaluate this question from the perspective of both an

optometrist and an ophthalmologist. I have taught ophthalmology residents and optometry students to use therapeutic agents in conjunction with these clinical skills.

The education of both professions in basic biomedical sciences, in the clinical sciences, and eventually patient care in hospitals, clinics and private practitioner's offices parallel one another.

During their education and training, both the optometrist and ophthalmologist are given a global view of ocular disorders, which are divided into the following sections:

1. Anterior segment disorders i.e. lids, conjunctiva, cornea, anterior chamber, iris and lens.
2. Posterior segment disorders i.e. choroid, retina, optic nerve.
3. Medical disorders
4. Glaucoma
5. Neuro-eye disorders
6. Surgery

Some optometrists and ophthalmologists may wish to develop an expertise in sub-speciality and may elect to take additional training.

The training of both disciplines is quite similar and intense with the "hands-on" clinical care of patients. Here

is where the optometric intern and ophthalmological residents learn to examine, diagnose, treat and manage ocular disorders.

It is almost a "one-on-one relationship" between the intern/resident and clinical instructor. In all cases, the intern/resident does the initial evaluation and work-up and then he presents that patient to the instructor. The case must be present in an organized fashion and the intern/resident must be able to justify and defend his diagnosis, treatment and management.

It is here that the intern/resident's basic knowledge of pharmacology and pathophysiology is tried and tested. He must be able to support his diagnosis with his clinical findings. He must justify his use or non-use of pharmacological agents with his knowledge of the disease processes.

In our clinics we have a saying, "Our sailors go to sea". The interns/residents not only have the book knowledge of the disease processes, but also have the experience in treating them. This is required to be a good clinician. At the end of clinic sessions, the important teaching cases are reviewed and discussed by all the staff to enhance the learning experience.

Primary care patients, whether seen in an optometric or ophthalmological institution, present with approximately the same percentage of healthy or unhealthy eyes. These

patients, depending on the circumstances, are either treated at the primary level or referred to another level of care.

Secondary and tertiary care patients with ocular problems are generally referred to an ophthalmological institution. It is here where patients with more advanced medical and surgical problems are evaluated and treated. Much of the ophthalmology resident's training is involved with caring for these patients.

In summary, I wish to state that ophthalmological training programs concentrate on advanced medical and surgical cases. Clinical optometric programs provide equal teaching experience in eye disorders and diseases at the primary level. Optometrists are more than adequately educated and trained to diagnose, manage and treat ocular conditions with therapeutic agents.

Thank you for allowing me to testify before your Board.

Joseph C. Toland, O.D., M.D.
Professor of Pathology and
Director of Ophthalmological Services
Pennsylvania College of Optometry
1200 West Godfrey Avenue
Philadelphia, PA 19141

COMMENTS OF JOHN BALDINGER, MD, BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

My name is Dr. John Baldinger. I am board certified ophthalmologist and have been in private practice in Fairfax, VA for the past two years. A substantial percentage of the patients I see and have seen in my practice of ophthalmology are referred directly by optometrists from the Northern Virginia Area. Approximately one half of my patients are referred for anterior segment consultation with the other half referred for posterior segment diagnosis and treatment.

I have also participated as a preceptor in the Virginia Optometric Therapeutic Course over the past 3 months. This 25 hour post graduate educational experience has allowed optometrists to observe and actively participate in the care of patients with anterior segment diseases involving therapeutic intervention. I have also been able to assess on an individual basis the knowledge of those individuals as they have rotated through my office.

As a result of these rather unique and close working experiences, I feel I can objectively comment on the abilities of optometrists in the Commonwealth to use therapeutic drugs in the treatment of ocular diseases.

The optometrists I have interacted with have proven themselves to be well versed in the diagnosis and management of diseases of the anterior segment.

In my opinion optometrists have sufficient training in pathology and pharmacology to safely prescribe FDA approved topical and oral medication for the treatment of eye disease. Although oral agents are not used to a large degree in ophthalmic medical practice, the practicing optometrist should have the ability to prescribe oral agents for medical intervention purposes. For example, optometrists should be able to prescribe oral antibiotics for the treatment of seborrheic blepharitis or preseptal cellulitis associated with a hordeolum, if topical treatment has proven to be ineffectual. Similarly oral analgesics may be needed for pain control in severe corneal abrasions when patient's do not respond to over the counter analgesics.

I can honestly say that in my two years in practice in Virginia, I have yet to see a patient referred to me that was held on to, too long by the optometrist or was misdiagnosed with harm done to the patients ocular well being.

The Virginia Optometric Association has provided a logical and rational credentialing process that will allow optometrists to deliver an excellence in delivery of therapeutic eye care. Organized optometry has shown in states where similar legislation has been passed and enacted, that ophthalmic related medicines can be delivered in a responsible and cost effective manner. I would wholeheartedly recommend to the Board of Medicine this expanded scope of optometric care.

COMMENTS OF THOMAS L. LEWIS, OD, Ph.D. BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

My name is Dr. Thomas Lewis. I am Dean of Academic Affairs at the Pennsylvania College of Optometry. I earned a Doctor of Optometry Degree from the Pennsylvania College of Optometry and a Ph.D. in Anatomy from the Daniel Baugh Institute of Anatomy, School of Medicine, Thomas Jefferson University. I completed a post-doctoral fellowship in the Department of Ophthalmology, School of Medicine, Washington University, St. Louis, Missouri.

Since 1975 I have been a member of the faculty at the Pennsylvania College of Optometry and have held various teaching, clinical and administrative positions. I have extensive teaching experience both at the undergraduate and continuing education levels. In addition to my role as Dean, I hold the rank of Associate Professor.

I thank you for the opportunity to be am here this morning to discuss some of the basic elements of optometric education as they relate to the diagnosis and treatment of ocular diseases.

The fundamental philosophy of professional optometric education is equivalent to that of all other health professional programs including medicine, dentistry,

osteopathy, and podiatry. The biomedical and clinical sciences are taught in the classroom, applied in the clinics and refined through internships, externships, and residencies.

As with other health professions, the vast majority of students entering optometry school have completed four years of college and hold a baccalaureate degree. Pre-requisite requirements for optometry are similar to other health care professional programs.

The basic biomedical courses taught in the schools and colleges of optometry are extensive. They include: Gross Anatomy, Histology, Human Physiology, General Biochemistry, General & Systemic Pathology, Microbiology, and Neurosciences. The intent of these courses is to give the student an in-depth understanding of the structure and function of normal body systems, in addition to basic histopathological concepts of general pathologies. The curricula focus on important aspects of such basic sciences as Endocrinology and Neurology given the increasing number of diseases which affect the eye arising from these systems.

Biomedical science courses also develop for students a greater understanding of systemic diseases. Courses in medical urgencies and emergencies and clinical medicine (taught by physicians) discuss the role of the primary care optometrist, including emergency medical care such as CPR, in the management of patients with systemic diseases.

Optometrists learn to recognize systemic disease through proper history and patient interview, direct observation, and various clinical signs and tests.

It is important to note that all the biomedical sciences taught in other health professional schools are also included in optometric curricula, and that the quality of the instructors is similar. In fact, many schools of optometry use the same faculty that teach in medical and dental schools.

Two areas which require special comment include pharmacology and the diagnosis and treatment of ocular diseases. On an average, 156 hours of pharmacology are presented at the schools and colleges of optometry. This is equal to or greater than the didactic education of other health professions that use therapeutic pharmaceutical agents. The courses are taught by highly qualified faculty, including pharmacologists. Within these courses, greater emphasis is placed on ocular pharmacology than in pharmacology courses presented to other health professionals. Pharmacology courses in optometry schools emphasize the systemic manifestations of ocular drugs, ocular manifestations of systemic drugs, drug toxicities and adverse reactions.

Ocular disease diagnosis and treatment is covered extensively and comprehensively in optometric curricula. The courses include a detailed discussion of the histopathological laboratory appearance, history, symptoms, clinical picture, etiology, prognosis and management of

ocular diseases. Special emphasis is placed on the importance and potentially life-threatening implications of certain systemic diseases which may manifest through ocular signs and symptoms.

The management of ocular disease is approached in a manner which supports the role of the optometrist in dealing with these conditions at the primary care level. This is done by emphasizing early diagnosis, by differentiating simple ocular conditions from those requiring advanced medical and/or surgical treatment, by differentiating those conditions which respond well to treatment vs. those that are resistant, and by stressing the need for timely and appropriate referrals. The diagnosis and treatment of ocular diseases is taught by highly qualified experts in optometry as well as board certified ophthalmologists and sub-special ophthalmologists.

Clinical training programs at the schools and colleges of optometry begin during the first year of the curriculum with maximum patient care exposure during years three and four. All schools and colleges support multi-disciplinary faculties of medical, optometric, ophthalmological, social, psychological, and rehabilitative practitioners and specialists.

At the Pennsylvania College of Optometry a student is scheduled for approximately 2,000 hours of clinical training and examine about 1,200 patients by graduation. Approximately 20% of the clinical encounters involve interaction with

physicians. Optometry students use therapeutic drugs with direct supervision on a daily basis. They apply the knowledge they have learned in the classroom on real patients in the clinic.

All therapeutic education is primary care oriented. Training is directed toward the diagnosis of patients' problems as the highest priority, treatment of non-surgical ocular conditions, and follow-up care to completion with adjustments in treatment or referrals when indicated.

At many schools and colleges of optometry, the on-campus clinical training is not the sole source of the students' clinical experiences. As in medicine, an externship program plays a significant role in training. Fourth year optometry students are required to complete externships in private practice, as well as institutional settings. Students gain exposure to and direct experience with diagnostic and therapeutic drugs, treatment of ocular diseases as well as observation of ocular medical and surgical techniques. Public, private and community resources with supervised preceptors serve as settings for externs. These would include ophthalmology practices and clinics, health maintenance organizations, military hospitals and clinics, V.A. hospitals, public health hospitals, community teaching hospitals, Indian health services, and multi-disciplinary clinics. Optometric practices in states which currently allow the use of therapeutic drugs to treat eye diseases are an ideal location for externships. At the completion of

their clinical training, optometry students have developed the appropriate competencies to accurately diagnose, treat and manage ocular disease.

Hopefully, this gives the committee an overview of the current status of optometric education. Thank you for allowing me to testify this morning.

Thomas L. Lewis O.D., Ph.D
Dean of Academic Affairs
Pennsylvania College of Optometry
1200 West Godfrey Avenue
Philadelphia, PA 19141
215/276-6220

COMMENTS OF LESLEY L. WALLS, O.D., M.D. BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

I. Introduction

My name is Dr. Lesley L. Walls and I am from Oklahoma where my job is Dean of the College of Optometry in Tahlequah, Oklahoma.

I am privileged to be a graduate of both optometry school (University of California at Berkeley-1968) and Medical School (University of California at Davis-1972).

My career has been in both Academic Medicine (Northeastern Ohio Universities College of Medicine, 1975-1977; University of Oklahoma Tulsa Medical College, 1977-78 and 1981-88 and Oral Roberts University College of Medicine, 1978-79) and Optometry (Northeastern State University, 1979-81 and February 1988 - present). I served as Department Chairman for Family Practice Tulsa Medical College from 1981-1988. I am very familiar with the curricular requirements of medical and optometric programs.

II.

Let me offer some specific observations on my own experience with optometric and medical education.

the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. The detailed ocular anatomy, ocular physiology, ocular pathology, and ocular pharmacology training in optometry school is far superior to the same ocular topics in any general medical school course in the country. This is not to slight medical education, there simply is not enough medical school curriculum time to devote to the eye because of training in vital organ systems such as the heart, lung, vascular system, etc.

III.

The possession of and use of sophisticated equipment such as binocular indirect ophthalmoscopes, slit lamps, goldman tonometers, goniolenses, Fundus photography, etc. are far superior in a modern optometric practice than in any primary care physicians office such as family practice, internists and pediatricians. Coupled with training and experience in the utilization of this type sophisticated equipment makes the optometrist better prepared to evaluate, diagnose and treat most ocular conditions when compared to the other listed primary health providers. This is not to demean or to cast these fine primary care providers in a bad light, rather, it is simply a fact that we must accept.

Because of the above there is no question that a well trained and well equipped optometrist can more than measure up to medical standards of care for primary physicians in the

into medicine more efficient. As well, this will save the patient a lot of inconvenience and time. I feel the Virginia State Board of Medicine should allow the people of the state of Virginia to benefit from modern optometry which includes the use of diagnostic and therapeutic pharmaceutical agents. I believe the key to utilizing these medications by any health care professional is proper education and training.

Lesley L. Walls, O.D., M.D.
Dean, College of Optometry
Northeastern State University
Tahlequah, OK 74464
918/456-5511

American Public Health Association

1015 Fifteenth Street, NW
Washington, DC 20005
202/789-5600

January 10, 1991

Hal V. Marsell
Chairman, Utah State Optometry Board
Utah State Legislature
190 South Fort Lane, #1
Layton, UT 84041

Dear Chairman Marsell:

I am very pleased to write in support of the legislation soon to be introduced which would update your state's laws concerning optometric care.

As you may know, at its 118th Annual Meeting, the American Public Health Association (APHA), which represents a combined national and affiliate membership of over 52,000 public health professionals and community health leaders, adopted a resolution entitled "Access to Treatment for Eye Care by Optometrists." A copy is enclosed for your immediate reference.

This resolution acknowledges that the expansion of clinical privileges of optometrists has increased the availability, accessibility, and cost effectiveness of eye care to the American public. The resolution recommends that States update their optometric practice acts to allow for optometric use of those diagnostic and therapeutic pharmaceuticals which have been determined by the State Board of Examiners in Optometry as being within the scope of competency of pharmaceutically certified optometrists. We further recommend that dispensing of such pharmaceuticals be regulated by state pharmacy laws.

Currently, ~~25~~ 30 states allow optometrists to use therapeutic drugs for the benefit of their patients. APHA urges your support for legislation which encompasses the principles endorsed in the APHA resolution, and would result in better access to comprehensive eye care of the American citizens.

I am confident that the citizens of Utah will be well served and will benefit greatly if comparable legislation is adopted by your state. As an MD. a Dean of a School of Public Health, and President-elect of APHA, I strongly endorse its passage.

Sincerely,

Joyce C. Lashof, MD
President-elect, APHA and
Dean, School of Public Health
University of California at Berkeley

JCL:mam/APHA

enclosure

OPTOMETRY: THE PROFESSION

Optometry is an independent primary health care profession.

It encompasses the prevention and remediation of disorders of the eye/vision system through the examination, diagnosis, treatment and/or management of visual efficiency and eye health. The recognition and diagnosis of related systemic manifestations are designed to preserve and enhance the quality of life and environment.

Doctors of Optometry are primary health care providers who diagnose, manage and treat conditions and diseases of the human eye and visual system as regulated by state law.

These health care professionals are specifically educated, clinically trained and state licensed to examine the eyes for the presence or absence of vision problems, eye diseases or ocular manifestations of systemic diseases such as diabetes, hypertension, hyperthyroidism, etc. The primary vision care needs of consumers have shaped the scope of optometric practice as it is today.

American Optometric Association

OPP
Optometric Protector Plan

Continuously
Serving Optometrists
Since 1973

November 7, 1991

TO WHOM IT MAY CONCERN:

RE: OPTOMETRIC PROTECTOR PLAN

This letter is in response to your inquiry relative to professional liability rates and therapeutic drug usage.

The Optometric Protector Plan which is endorsed by the American Optometric Association currently insures over 7,000 O. D.'s nationwide. Our professional liability experience reflects both therapeutic and non-therapeutic states and the information provided is based on this information.

Poe & Associates, in the past has reviewed on a comprehensive basis the underwriting results for three major carriers for a period of seven years, and found that there is no significant actuarial coordination between therapeutic drug usage and liability insurance rates based on the current underwriting results.

Our current carrier of record, Great American Insurance Companies, does not charge a premium differential or surcharge for therapeutic drug usage in any of the states in which they are currently providing coverage. Because claims and premiums are so closely related to incidents of harm and injury to patients, we do not have evidence at this time that there is a correlation between the use of therapeutic drugs by Optometrists and malpractice claims.

Please contact me if I can be of any further help.

Sincerely,

Kathy Szuszczewicz

Kathy Szuszczewicz
Program Coordinator

KS/sv

National Administrator
Poe & Associates, Inc.

P.O. Box 1348
Tampa, Florida 33601-1348
(813) 222-4100
Fax (813) 221-4109

COMPARISON OF EDUCATION OF GENERAL PRACTITIONER & OPTOMETRIST

GENERAL PRACTITIONER*		OPTOMETRIST**	
Undergraduate School		Undergraduate School	
Medical School (4 Years)		**Optometry School (4 Years)**	
Systemic Disease	9 hrs.***	Systemic Disease	6.5 hrs.***
Pathophysiology (Does NOT include ocular disease)	9	Pathophysiology (Includes ocular disease)	12.0
TOTAL	18	TOTAL	18.5
Pharmacology	8	Pharmacology	9.5
Human Anatomy & Physiology	29	Human Anatomy & Physiology	17.0
Neurophysiology	6	Neurophysiology	4.5
TOTAL	35	TOTAL	21.5
Clinical experience in ocular conditions and disease	4	Clinical experience in ocular conditions and disease	47

General Practitioners have a 1-year internship after medical school, but the internship is in a hospital and the General Practitioner would not be likely to see routine ocular problems.

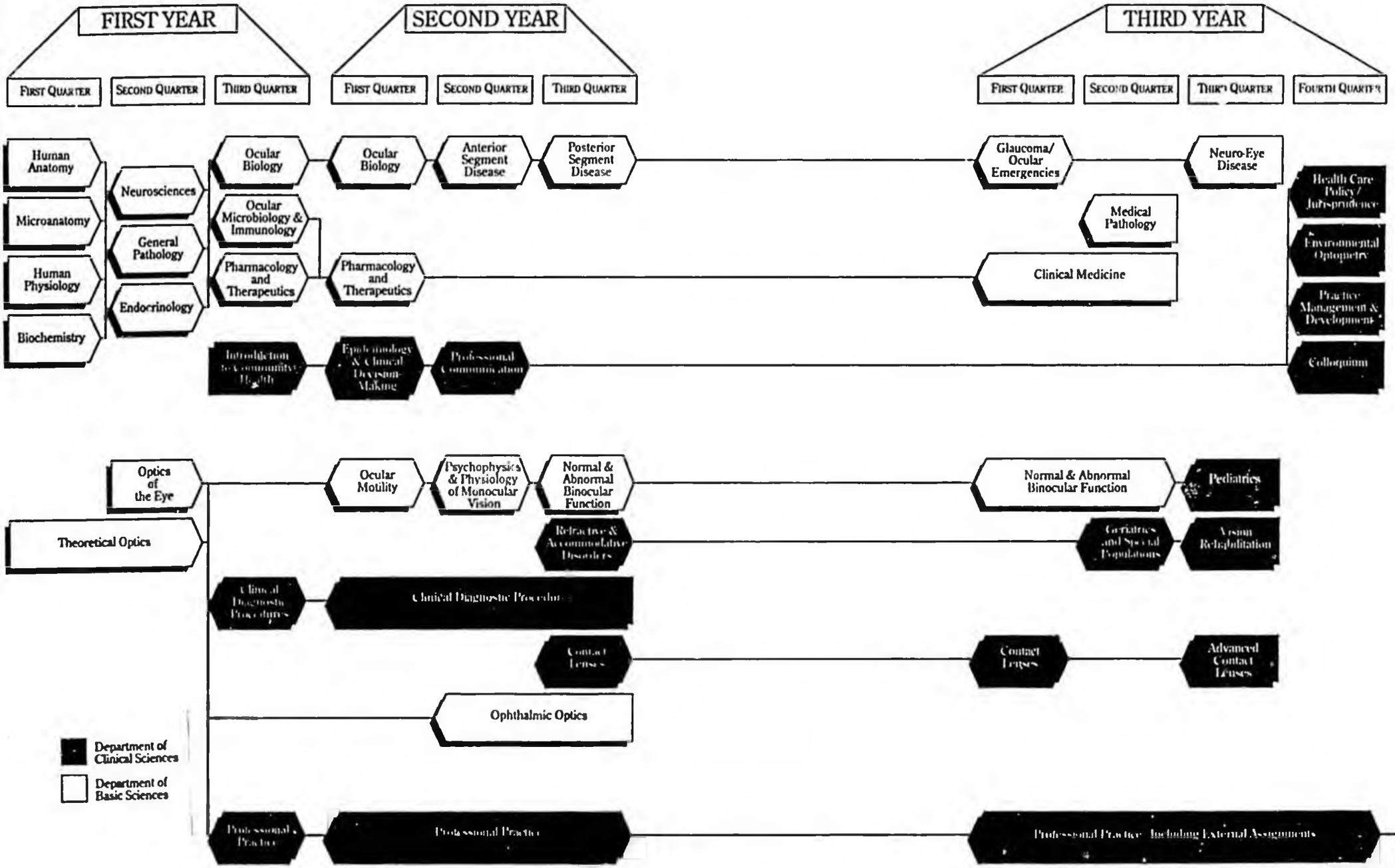
---

* Hours reported in CU Health Sciences School of Medicine Schedule of Courses 1987-88.

** Hours reported in The Southern California College of Optometry 1987-89 catalog.

*** Hours reported in quarter hours, not classroom hours.

Four-Year Optometric Degree Program



During the four years, seven elective courses are required

...nclose or bind a group
..., or as a means of at-
... for muscles at their
...nsertion.
...a orbitale.
...ris, a. Tenon's capsule.
...neal (ap'o-plek"se).
... of blood into the cor-

...nal. Copious hemor-
... the retina.
...'ilb). A unit of lumi-
...l to 1/10 millilambert.
...lambert.
...ah-ra'tus, -rat'us). 1.
... group of organs, or
...gans, which collec-
...m a common function.
...tion of instruments,
... implements used for
...k, as an experiment
...ion.

...e a. Those parts of
...an, other than the
...e and the receptor
... are essential ... the
... of the organ. ...
...ld include all ...
...han the optic ner...
... and cones of th...

...e a. The structures
...hich are related to
...n: the ciliary ap-
... crystalline lens,
...iary muscle and
... structures other
...ne lens which
...commodation;

...-forming and
...stem, com-
...d accessory
...d margins,
...imal lake,
...ll or lac-
...iculus
... sac,
...'s

the eye considered collectively. See under *muscle* for the specific muscles involved.

nervous a. The sensory and the motor nerves of the eye and the orbit considered collectively. See under *nerve* for the specific nerves involved.

refractive a. Cornea, aqueous humor, crystalline lens, and vitreous humor considered collectively; the surfaces and the media traversed by light entering the eye and involved in the production of the retinal image.

visual a. The two eyes, their extrinsic muscles and other contents of the orbits, the nerves, the pathways, and the visual cortex, considered collectively. Syn., *visuum*.

apparent height; magnification; magnitude; movement; position; pupil; size; strabismus. See under the nouns.

apparition (ap"ah-rish'un). 1. A supernatural visual manifestation. 2. A visual hallucination.

appearance. 1. The distinctive characteristics or features of an object or an individual as noted by visual observation. 2. The originating of an experience, particularly visual. 3. An incorrect visual or other impression.

appendages of the eye (ă-pen'dih-jez). The accessory structures or adnexa of the eye, including the lacrimal apparatus, the conjunctiva, the cilia, the supercilia, the eyelids, and sometimes the extraocular muscles.

apperception (ap"er-sep'shun). The action of past experience upon received sensory stimuli, resulting in individual differences of interpretation of the same sensory stimuli.

applanatio corneae (ap"lah-na'she-o kor'ne-e). A flattened cornea due to degenerative changes.

applanation (ap"lah-na'shun). An abnormal flattening of a convex surface, especially of the cornea or the crystalline lens.

apraxia (a-prak'se-ah, ā-prak'-). The inability to accomplish an intended or purposeful movement, the nature of which is

...pparatus. (1) Superior lobe and (2) inferior lobe of lacrimal gland. ...ior canaliculus. (5) Lacrimal sac. (6) Nasolacrimal duct. (From Text-book ...halmology, Vol. 1, Duke-Elder, Henry Kimpton, 1942)

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

DICTIONARY OF VISUAL SCIENCE

SECOND EDITION

A modern comprehensive dictionary covering the terminology of the visual sciences, including the fields of ocular anatomy, ocular physiology, ocular pathology, ocular embryology, neuro-ophthalmology, ocular histology, ocular genetics, comparative anatomy of the eye, ocular prosthetics, physiological optics, psychological optics, ophthalmic optics, geometrical optics, ocular refraction, orthoptics, visual training, dispensing, aniseikonia, perimetry, contact lenses, subnormal vision aids, occupational vision, and motorists' vision, and also including the phases of remedial reading, statistics, illumination, and physical optics that relate closely to vision.

Illustrated

EDITED BY

MAX SCHAPERO, B.S., O.D. DAVID CLINE, B.S.

HENRY WILLIAM HOFSTETTER, B.S., M.S., Ph.D.

CHILTON BOOK COMPANY

Radnor, Pennsylvania

nclose or bind a group
, or as a means of at-
for muscles at their
nsertion.
a orbitale.
ris, a. Tenon's capsule.
neal (ap'o-plek"se).
of blood into the cor-

nal. Copious hemor-
the retina.
'ilb). A unit of lumi-
l to ⅓₀ millilambert.
otlambert.
'ah-ra'tus, -rat'us). 1.
r group of organs, or
:gans, which collec-
m a common function.
tion of instruments,
implements used for
k, as an experiment
ion.
e a. Those parts of
an, other than the
/e and the receptor
are essential for the
of the organ. In the
ıld include all struc-
han the optic nerve
; and cones of the

e a. The structures
hich are related to
on; the ciliary ap-
the crystalline lens.
ciliary muscle and
e structures other
stalline lens which
o accommodation;
dy.
e tear-forming and
g system, com-
mal and accessory
s, eyelid margins,
ac, lacrimal lake,
ı, canaliculi or lac-
ommon canaliculus
aier, lacrimal sac,
ıct, and Hasner's
erior meatus of the

e intraocular and
r musculature of

the eye considered collectively. See under *muscle* for the specific muscles involved.

nervous a. The sensory and the motor nerves of the eye and the orbit considered collectively. See under *nerve* for the specific nerves involved.

refractive a. Cornea, aqueous humor, crystalline lens, and vitreous humor considered collectively; the surfaces and the media traversed by light entering the eye and involved in the production of the retinal image.

visual a. The two eyes, their extrinsic muscles and other contents of the orbits, the nerves, the pathways, and the visual cortex, considered collectively. Syn., *visuum.*

apparent height; magnification; magnitude; movement; position; pupil; size; strabismus. See under the nouns.

apparition (ap"ah-rish'un). 1. A supernatural visual manifestation. 2. A visual hallucination.

appearance. 1. The distinctive characteristics or features of an object or an individual as noted by visual observation. 2. The originating of an experience, particularly visual. 3. An incorrect visual or other impression.

appendages of the eye (ăpen'dih-jez). The accessory structures or adnexa of the eye, including the lacrimal apparatus, the conjunctiva, the cilia, the supercilia, the eyelids, and sometimes the extraocular muscles.

apperception (ap"er-sep'shun). The action of past experience upon received sensory stimuli, resulting in individual differences of interpretation of the same sensory stimuli.

applanatio corneae (ap"lah-na'she-o kor'ne-e). A flattened cornea due to degenerative changes.

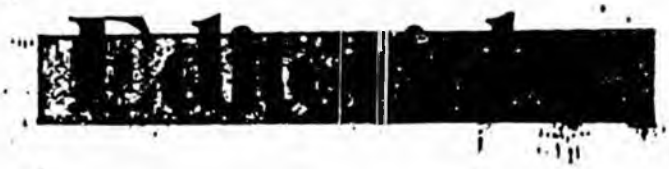
applanation (ap"lah-na'shun). An abnormal flattening of a convex surface, especially of the cornea or the crystalline lens.

apraxia (a-prak'se-ah, ă-prak'-). The inability to accomplish an intended or purposeful movement, the nature of which is

Fig. 3. The lacrimal apparatus. (1) Superior lobe and (2) inferior lobe of lacrimal gland. (3) Superior and (4) inferior canaliculus. (5) Lacrimal sac. (6) Nasolacrimal duct. (From Text-book of Ophthalmology, Vol. I, Duke-Elder, Henry Kimpton, 1942)

The Evening Sun

A12 Baltimore, Thursday, June 2, 1988



Double vision

Governor Schaefer justified his veto last week of the "eye drops" bill by saying the measure would have "lowered the standard of medical care here." In fact, the governor's action ensures that Maryland, alone in the nation, will retain a double standard of eye care — one for those who have access to an ophthalmologist, and another for those who cannot afford the higher fees or live in rural areas of the state not served by an ophthalmologist.

The "eye drops" battle has been a legislative fixture for so long that it can almost be seen as an duel between lobbyists. But the political fight shouldn't obscure the real issue here, which is rank protectionism for one branch of the medical profession. Maryland's law governing the practice of optometry was adopted in 1914, and since then not one word has been changed. Meanwhile, every other state in the nation has allowed optometrists to use eye drops ("pharmaceutical agents") in order to check patients for disease. This is not a radical idea; optometrists everywhere else in the country routinely use this important diagnostic tool. Maryland optometrists are trained in the use of diagnostic eye drops and are authorized to use them in the state Veterans Administration Hospitals or in public health facilities, but not in their private offices.

One result of Maryland's backward law is that the number of new applicants taking the state's optometry exam has dropped by half in the last five years. In other words, affordable eye care will become harder to procure — a sign that does not bode well for vision in this state.

Second Opinion

Frank Pesci

Last week, Gov. William Donald Schaefer vetoed a bill that would finally allow optometrists in Maryland to use eyedrops for diagnostic purposes. For years the bill has been a turf battle in Annapolis between optometrists and ophthalmologists.

Schaefer's veto makes Maryland the only state left which still denies optometrists the right to use eyedrops to dilate patients' pupils. Can you imagine that?

Schaefer said he was swayed by medical authorities and his own ophthalmologist who requested he veto the bill. He said he didn't believe that optometrists' training requirements adequately compare to the training required of ophthalmologists.

Sen. Arthur Dorman, D-21st-Beltsville, an optometrist, didn't buy Schaefer's reasons for the veto.

Dorman would like to know the real reason for the veto.

Dorman knows the real reason. He just doesn't want to say. So I'll say it for him.

The real reason is Bruce Bereano, Annapolis' number one money-making lobbyist. Bereano represents the ophthalmologists, and in 1986 he raised tens of thousands of dollars for Schaefer's gubernatorial campaign.

Two months ago, I ran into Bereano after breakfast at the Maryland Inn. Winking, he spoke about getting a veto of the eyedrop bill if it passes. Do you see a quid pro quo?

I learned a long time ago that the sleaze factor in politics comes in bipartisan doses. The Republicans have their Ed Meese, and in Maryland the Democrats have Schaefer and Bereano.

Frank Pesci of New Carrollton, who writes regularly for this page, is a former member of the Maryland House of Delegates.

Opinion

Schaefer's eye-drop veto

Gov. William Donald Schaefer was in a quandary last week. He had to decide whether to sign or veto a bill allowing optometrists to administer eye drops to dilate patients' pupils, a procedure that helps the optometrists detect eye disease.

On the side of signing the bill were the governor's own health secretary, optometrists, consumers, the General Assembly, which passed the bill earlier this year, and the fact that every other state in the union allows optometrists to administer eye drops.

On the side of vetoing the bill were ophthalmologists, who stand to lose customers and money if the bill becomes law, and Bruce Bereano, the ophthalmologists' high-powered lobbyist, who also raised tens of thousands of dollars for Schaefer's gubernatorial campaign.

No contest, if you're this governor. Schaefer vetoed the bill.

The Impact Of The Use By Kansas Optometrists Of Therapeutic Pharmaceutical Agents

By Stacy Fitch, O.D.

ABSTRACT: From July 15, 1987 through December 31, 1988, the Kansas Optometric Association collected information from Kansas optometrists regarding the number of diagnostic cases seen, their respective therapies, and the number of miles saved. This paper attempts to show the impact of the Kansas therapeutics law on optometrists and their patients.

INTRODUCTION

April 17, 1987 was just a typical day for most of us. But, for Kansas optometrists, it was a milestone. On that day, Kansas became the 17th state to pass a therapeutic law, which has greatly expanded the practice of optometry in Kansas.

The Kansas Optometric Association (KOA) conducted a study for the first year and a half after implementation of this law which asked KOA members to voluntarily keep track of all diagnoses made, therapies, the number of therapeutic encounters, the miles saved, and the referrals made to other doctors. This information was returned to the Kansas Optometric Association.

The Kansas therapeutics law for optometry includes the administering and dispensing of topical pharmaceutical drugs, as well as, the removal of superficial foreign bodies from the cornea and conjunctiva. Any anti-inflammatory agents administered are limited to a 14-day supply and may only be used topically.

RESULTS

Forty-three offices representing 47 optometrists responded to the study. This represents 23% of the 203 optometrists initially certified at SBEO to use therapeutics. Therefore, the results of this study will significantly understate the actual impact. Overall, the total mileage saved by the patients treated by optometrists during the 1½ year period is over 128,000 miles. This represents a major savings of time and out-of-pocket travel expenses for patients.

In Table 1, 23 major diagnoses are listed, with the number of cases of each per month, dating from July 1987 through December 1988. The cases that were referred to another doctor are not included in the table. Two cases of scleritis treated by rural optometrists are not included in the table. A case of scleral melt secondary to cataract surgery is not listed in the table, but is included in the study. This case was co-managed by an optometrist and a surgeon. This case alone saved the patient 1600 miles, encompassing all trips made to the optometrist.

The percentage of cases seen by optometrists practicing in cities versus those practicing in rural areas is considered in Table 2.

Table 3 shows the percentage of cases per month.

DISCUSSION

In Table 2, the greatest percentage of cases were seen by rural optometrists. It would seem that patients are turning to optometrists for their primary eye care in rural areas because of greater convenience. However, it is difficult to draw concrete conclusions in this regard because the majority of optometrists responding to this study are optometrists practicing in rural areas. It may be reasonable to assume that urban optometrists didn't respond because the miles saved would not be great. However, a higher urban OD's response would have reflected significant cost savings over emergency room visits.

In Table 3, the greatest percentage of cases seen per month occurs approximately one year after the implementation of the therapeutics law. There could be several reasons for this. The patients may be more aware of what optometrists can treat now than when the law first passed. Optometrists may also be more confident in treating more sophisticated ocular maladies. Also, as found in the study, optometrists are receiving more referrals from hospitals and general physicians.

CONCLUSION

Prior to April 17, 1987, none of the cases in this study would have been handled by optometrists because the Kansas optometry laws did not allow it.

The mileage saved by the patients became very important in rural areas, which have an optometrist available, but not an ophthalmologist. Since Kansas is largely a rural state, patients are benefiting from the revised optometry laws in time saved, money saved, elimination of unnecessary referrals, as well as improved health care.

ACKNOWLEDGEMENTS

Thanks to Michael P. Malone, O.D. for his assistance in the study and for the use of his optometric office to compile the information, the KOA for supplying the material to write this paper, and the many optometrists who participated in this study.

REFERENCE

Kansas Optometry Laws, 65-1501, 65-1501a.

APHA recognizes contributions to public health, vision care

ATLANTA— The Vision Care Section (VCS) of the American Public Health Association (APHA) recognized the contributions of a public health leader and a public policy center at the association's 119th annual meeting.

Recognized for his important contributions to public health in general and vision care in particular, was Harris Nussenblatt, O.D., Dr.P.H., of Houston, TX, winner of the section's 1991 Distinguished Achievement Award. Dr. Nussenblatt is a founding member of the Vision Care Section and served as chair from 1982-84. He also served as section councilor, program chair and editor of the section's newsletter for many years. He was also cited for his committee work for the American Optometric Association (AOA) and the Association of Schools and Colleges of Optometry (ASCO) by Les Caplan, O.D., M.P.H., awards chair.

"In summary, Dr. Harris Nussenblatt's record is one of academic excellence with significant contributions to public health and eye care issues. His work has always been attune to changes in health care delivery while being both a leader and team player — all of which has improved the health and well-being of the public," said Dr. Caplan.

Harris Nussenblatt, O.D., Dr. P.H.

The section's Outstanding Paper Award went to Mordachai Soroka, Ph.D., of the Center for Vision Care Policy, State College of Optometry, State University of New York. The award paper, titled "Comparison of Examination Fees and Availability of Routine Vision Care by Optometrists and Ophthalmologists," was recently published in *Public Health Reports*. Dr. Soroka's national survey determined that ophthalmologists' fees are $19 more than optometrists' fees for routine eye examination. In addition, he reported that the waiting time for routine examinations with ophthalmologists was 15 days longer than for optometrists, which added a barrier for access to services.

The VCS sponsored numerous papers presented during the conference. The papers highlighted a patchwork quilt of subjects and their effect upon public health. Panel presentations addressed model diabetes control programs, screening underserved populations, and eye care in underdeveloped countries.

Papers were presented by ODs as well as physicians, nurses, government representatives and scientific researchers, according to Debbie Hettler, O.D., M.P.H., Chicago, IL, program chair for the VCS.

"The meeting offered a great opportunity to interact with health professionals from around the world and enhance the role of optometry in the total health care system," said Ian Berger, Ph.D., VCS Action Board representative, Houston, TX.

SCCO program covers AIDS and vision problems

FULLERTON, CA— "Eye/Vision Problems Associated With AIDS," was the topic of a recent, special edition of the Southern California College of Optometry's (SCCO) Vision and You cable television program. The program featured SCCO faculty members John Nishimoto, O.D., and Russell Jew, O.D., discussing the devastating effect of AIDS on the eyes. In some cases, eye signs of AIDS are the first to be noticed as the retina is almost always affected by the malady. AIDS can have serious consequences on the patient's vision, the doctors noted.

Dr. Nishimoto and Dr. Jew emphasized that all HIV-positive patients should have an eye examination every three months. Sometimes, the first sign of full-blown AIDS is seen in the eye and treatment to prevent the AIDS virus from multiplying rapidly must be started in order to save at least some vision.

The AIDS virus has been noted in the tear layer of the eye, so optometrists should

Frescura, luminary of European optometry, dies at 85

Romeo Frescura, a founding member of the European Optometry Society (SOE), has died at the age of 85 in Imperia, Italy. The second of four generations in the optical field, Frescura was a consultant to the Italian government for eye care and served as president of the optometric trade union there. Active in optometric education in Italy, France and Germany, he served as president of the SOE for nearly 20 years. He is survived by his son, Ugo Frescura, president of the SOE since 1985.

Deaths

ST. LOUIS-- The American Optometric Association derives its great strength and spirit from its people, and mourns all those it loses. The following are those members whose passing has been reported to the *AOA News* as of Dec. 1, 1991.

EDITORIAL

Lyman C. Norden, O.D., Editor

What makes optometric primary eye care better?

This issue contains another of several letters I've received stating that optometric primary eye care is better, not just less costly than ophthalmologic. Actually, I agree. Now how do we convince others?

It's easy to show that optometric care is less costly. All you have to do is look at financial balance sheets. Look at optometric training sites versus medical. Look at HMOs and governmental agencies in which optometrists provide the primary eye care. It's also easy to show that optometric training in primary vision care is better. All you have to do is look at curriculum. Optometric training involves far more hours in optics, refraction, and psychophysics of vision than does medical – and primary *vision* care is what most consumers really want from their eye care providers.

Ophthalmology, however, counters with a compelling argument that *medical training* makes its delivery of primary ocular *health* care superior to optometry's. Of course optometry then has to convince anyone still listening that its training in ocular health care is good enough to do the same. Perhaps we should start with our own compelling argument that optometric training is superior to medical training for the delivery of primary eye care, which includes *both* primary vision care and primary ocular health care. But first we must ask ourselves, "What is there about optometric training that results in better primary ocular health care?" Following are a few observations and opinions from one who has spent some 20 years in multidisciplinary practice settings, optometric training sites, and affiliated medical training sites.

First there is the matter of attitude, developed either in training or prior to training and then nourished by it. Medicine has a long-standing and often-dramatized association with life-and-death issues in patient care and in training for patient care. We see it in the media every day and we hear it in legislative sessions every year. It would be understandably difficult to train in such an environment without being caught up in the egocentrism that can result. This is not saying that egocentrism is bad. It's probably necessary for making clinical decisions about death and serious illness. But let's be realistic. People don't typically seek primary eye care for fear of death, blindness, or any other disabling illness. Most people seek primary eye care because they either want to see better or look better, or both. Optometrists seldom have trouble coming back down to earth when dealing with the vast majority of patients who simply want primary vision care. Similarly, optometrists seldom have trouble coming back down to earth when dealing with legislators and policy makers who simply want what is best for their constituents.

Optometrists are better able to communicate one-on-one with their patients. This is one of the principal reasons why optometry has been able to survive and grow within our medicine-dominated health care system. When given a choice, most people elect to receive their primary eye care from an optometrist. An important reason for this is that optometrists are better able to understand what people really want and need from their primary eye care providers. This ability to communicate effectively with primary care patients better enables the optometrist to elicit compliance in the pharmacologic management of eye disease.

I believe the development of these communication skills is inherent in optometric training because that training is based upon subjective refraction. In subjective refraction, the doctor in training bases virtually every step of the clinical examination on the patient's response to a question. How many doctors do you go to for health care who actually listen and respond to virtually everything you say for 30 minutes or more? How many doctors do you go to for health care who actually base their diagnoses more upon what you tell them than upon what they see in your tests? Unlike optometric training, fundamental medical training involves numerous clinical decisions based more upon laboratory tests and clinical observations than upon conversation with the patient. Optometrists, however, talk *with* their patients. This is why optometrists are more likely to obtain compliance from patients requiring ocular disease management.

I believe these communication skills are further refined in optometric training because that training involves both the prescription and fitting of prosthetic devices (eyeglasses and contact lenses). By comparison, medical training typically involves the prescription of pharmacologic agents, dispensed by a third party. Prescription medications are purchased and dispensed away from the prescribing doctor's office and quickly forgotten, whether they worked or not. Who wants to pay for another office visit and lose another half day in the doctor's waiting room because they're not sure a prescribed medication really worked? A prosthetic device, however, requires individualized fitting and when it doesn't perform satisfactorily, the patient usually knows it and returns it to its source, at which point the underlying problem must be confronted. Eyeglasses obtained from the prescribing optometrist which don't perform as expected are usually brought to the attention of the doctor in a remarkably efficient feedback loop. This direct feedback system is not a part of ophthalmologic training. Refracting ophthalmologists insulate themselves with opticians (and seem to think they are more virtuous than optometrists for doing so).

Not only must optometrists constantly stand ready to prove themselves to the patients for whom they prescribe, they must do so at virtually every turn within the total health care system. Medicine, because of its status in the eyes of the public, legislators and policy makers, seems always to be assumed right in everything it says until overwhelmingly proven wrong. Optometry on the other hand seems always to be assumed wrong until it proves itself incontrovertibly right.

Being challenged at every turn ultimately makes optometry better at what it does. Optometry has always had ophthalmology nearby, eager to point out any perceived errors in clinical judgement when a case goes bad. This naturally makes optometrists more conscientious and conservative in their treatment of patients. What other health care profession has a more active and therefore more effective quality assurance program?

Nothing in this discussion should be construed as a criticism of medical training. I see nothing wrong with medical training, nor am I in a uniquely credible position to criticize it. But I know what I like, and don't like, in every brand of health care I consume – and so do our patients. The point is that, for the provision of primary eye care, optometric training is better than medical training.

Optometric Education

The growth of the optometric profession is in no small measure due to the remarkable expansion of optometric education during the past thirty years. Because optometry is a relatively young profession, it has been able to benefit from the tremendous expansion in technology during recent years. Many people are not aware of the truly significant changes that have recently taken place in the profession and its educational base.

Fifteen schools and colleges of optometry in the United States now provide an educational experience that is equivalent in length and scope to that which is provided by schools of medicine and dentistry. All medical, dental and optometry programs are four years in length and require the same level of professional training. In fact, a comparison of the current catalogs of the University of North Dakota School of Medicine (UND) and Southern California College of Optometry (SCCO) demonstrates that the admission requirements of SCCO are actually more stringent than those of the UND.

Admission Requirements (Quarter Units)

	UND	SCCO
Calculus	Not required	3-4
Biology or zoology	8	8
Microbiology	Not required	4
Physics	8	12
General chemistry	8	12
Organic chemistry	8	4
Psychology	3	8
English	6	8
College Algebra	3	Not required
Total hours required	**90**	**90**

During the first two years of both professional programs, students receive extensive training in basic health sciences, such as pharmacology, anatomy, physiology, neurosciences, and pathology. The second two years are more clinically oriented; the medical student is trained in all aspects of medical care while the optometry student concentrates on the eye and visual system. The result is that the optometry graduate completes his training with much more extensive and in-depth training in the eye and in the diagnosis and treatment of its abnormalities than does the medical school graduate.

After graduation from the four-year professional programs, both the optometrist and the physician are examined and licensed by appropriate agencies of the state. This license allows the physician to practice all aspects of medicine and surgery, including the diagnosis and treatment of eye diseases and the performance of eye surgery. Although most physicians undergo additional training in one of the medical or surgical specialties, no further testing or licensure is required in order for them to practice as a specialist. Therefore, even though some physicians have undergone several years of additional training to become pediatricians, *any* physician is permitted to treat diseases of children, and even though some physicians have undergone several years of additional training to become obstetricians, *any* physician is permitted to deliver babies. Similarly, even though some physicians undergo several years of additional training to become ophthalmologists, *any* physician may treat diseases of the eye.

For legal and licensure purposes, it is assumed that the training received in the four years of medical school qualifies the graduate to practice all aspects of medicine with reasonable competency. This assumption appears to work very well since there appears to be little pressure for changes to the Medical Practice Act which would require that only specialists be allowed to treat various types of conditions.

This same assumption might well be applied to other health professions as well. If it can be demonstrated that the training a health professional receives in a given area is equivalent to or superior to that received by a physician, there seems to be no logical reason why he should not be allowed to do what the physician does in that area of health care. Since only about 4.5 percent of all physicians are ophthalmologists, it makes good sense to permit the doctor of optometry to provide primary eye care whenever possible.

Benefits of Use of DPAs Continue

Since the use of diagnostic pharmaceutical agents (DPAs) by optometrists was authorized by the 1979 North Dakota legislature, the benefit to the public of this action has continued to be demonstrated. More than 90 percent of North Dakota optometrists have been certified, and most use DPAs routinely in their diagnosis and treatment of vision problems. Contrary to the dire predictions of those who opposed the 1979 legislation, no adverse effects have been reported. In fact, the Optometry Board has not received any formal complaints or reports of problems associated with the use of DPAs by optometrists. Professional liability premiums, perhaps the best indicator of whether or not problems are occurring, have not been affected. The action of the 1979 legislature has proven to have been prudent and in the best interests of the people of North Dakota.

The North Dakota experience is the same as that in the other forty-eight states that currently permit optometrists to use DPAs. In none of these states has significant evidence been brought forth to suggest that any adverse effects are occurring. It is also worthy of special note that in the twelve states which permit optometrists to use therapeutic as well as diagnostic agents, no reports have been made of any problems associated with their use. In fact, it has been well

documented that the therapeutic agents are even less likely to cause complications than are the diagnostic agents. This underscores the fact that the optometrist of today is capable of using both diagnostic and therapeutic pharmaceuticals safely and effectively in his or her practice.

Because of the much broader geographic distribution of optometrists and the fact that fees charged by them are generally less than those charged by ophthalmologists, major savings to the public are realized when optometrists are permitted to practice at their highest level of training. The necessity of referring persons with relatively minor eye injuries or infections to a surgical eye specialist or a hospital emergency room always results in a charge for the second examination and frequently results in the loss of several additional hours from the patient's work and/or the travel of many additional miles.

Optometry *IS* Primary Eye Care

Analysts of the health-care delivery system have divided it into three broad categories which they have labeled primary care, secondary care, and tertiary care.

Primary care is that level of care delivered by "first contact" providers. These are the doctors first contacted by a person in need of health care, and they are able to diagnose and treat the great majority of persons they see. It has been estimated that from 85 to 95 percent of all health care can be classified as primary care. In general, primary-care providers do relatively little of their work in hospitals. The American Medical Association considers family and general practitioners, pediatricians, internists, and obstetrician/gynecologists to be primary medical care providers. Other primary-care providers include general dentists, optometrists and podiatrists.

Secondary-care providers are generally those who have received additional specialized training beyond that which is required of primary-care providers. Persons with unusual or complicated problems or those who require more than very minor surgery are generally referred to a secondary-care provider by a primary-care provider. Most surgeons are classified as secondary-care providers, and secondary care involves more use of hospitals and specialized facilities than does primary care. Among the medical specialties, orthopedic surgeons, ophthalmologists, anesthesiologists, and cardiologists are examples of secondary-care providers. Non-medical secondary-care providers would include dental specialists, such as orthodontists and periodontists, and optometrists who limit their practice to contact lenses.

Tertiary-care providers are those who specialize in the diagnosis and treatment of rare conditions. Their practice is almost always hospital based and requires additional training beyond the secondary level and use of sophisticated techniques and instruments. Examples of tertiary-care providers would be open-heart surgeons, brain surgeons, ophthalmologists who repair retinal detachments, and organ transplant specialists.

Because of the additional training and skills required to practice at the secondary and tertiary levels, the care provided is usually more expensive than that provided at primary level. Even in cases where the fees charged are the same, when the costs to society of education and training are considered, the cost of secondary and tertiary care is higher. Since the vast majority of all care can be provided at the primary level, it makes good sense from an economic standpoint to have as much care as possible provided at that level, and in most cases, it is. For example, even though a cardiologist may have more training in the management of high blood pressure, family practitioners are perfectly capable of managing uncomplicated cases. And even though an orthopedic surgeon may have more training in the anatomy and function of the joints, a pediatrician is perfectly capable of treating a child's simple sprained ankle.

Similarly, optometrists, although they do not have the same training as do ophthalmologists, are perfectly capable of managing uncomplicated eye conditions. Their education and training in the diagnosis and treatment of eye problems is much more extensive than that of most physicians, and their past record of conscientious, conservative care is evidence of their ability to recognize and refer to other providers those conditions that require care at the secondary or tertiary level.

Health Care Not Necessarily Medical Care

Although the terms *health care* and *medical care* are often used interchangably, they do not really mean the same thing.

Health care is a broad term that refers to the entire area of maintenance of physical well-being. *Medical care* is much more limited in that it refers to health care which is provided by medical doctors.

Although the various areas of health care seem to be fairly well defined, many areas overlap. For example, the Medical Practice Act, since it was the first to be enacted, is all-encompassing and permits the physician to practice all aspects of health care regardless of whether or not he or she has any training in that area. Thus, any physician may legally fill teeth or prescribe eyeglasses. On the other hand, certain procedures which would usually be considered the exclusive domain of physicians are done by some other health-care providers. Dentists are permitted to use general anesthetics and prescribe oral antibiotics and potent pain-

Basic Principles in Pharmacology

The range of hours in category 1 of the instrument is 15. Four schools spend only three hours and two spend 18 hours on this category. The overall mean for the entire sample is 8.71 hours. An F-ratio of 5.48 shows that there are significant differences among the three school types in hours spent in this study category.

Schools of optometry are not significantly different than either schools of medicine ($t = 2.51$, $df = 16.2$, $p = .02$) or schools of dentistry ($t = 0.04$, $df = 14.3$, $p = .97$). Medical schools do, however, spend more hours on this category than schools of dentistry ($t = 3.01$, $df = 30.8$, $p = .005$).

Drug Effects on the Nervous System

The second category for comparison within the pharmacology study instrument involves class hours spent studying drug effects on the nervous system. The range of hours was found to be 23 with two schools spending only five hours and one school spending 28 hours on this category.

The mean is 13.24 overall and an F-ratio of 8.61 showed that there are significant differences among the three school types on this category of the instrument. Comparatively, optometrists and dentists do not differ on this category ($t = 0.99$, $df = 13.1$, $p = .922$), whereas medical schools devote more hours than either optometry ($t = 2.97$, $df = 14.8$, $p = .009$) or dental schools ($t = 3.83$, $df = 30.9$, $p = .001$).

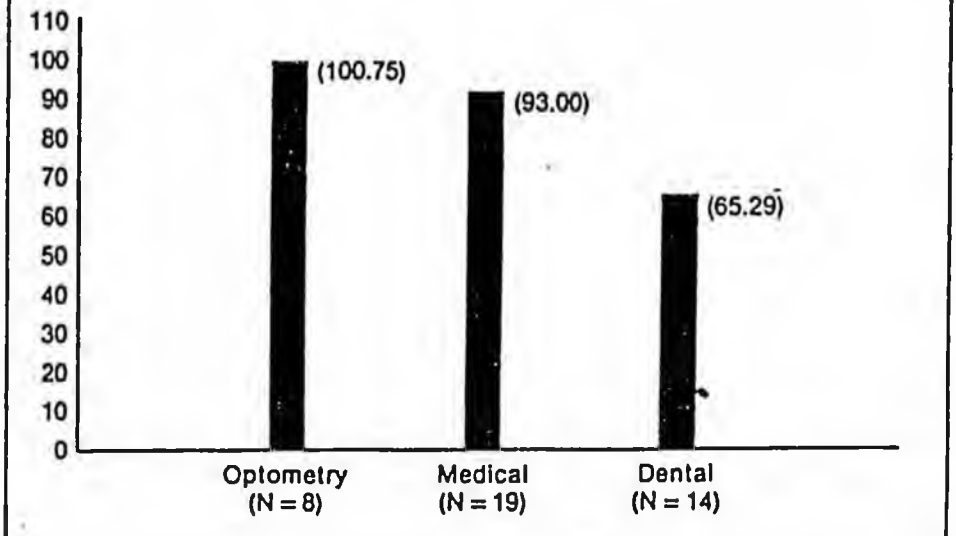
Psychopharmacology

The range for hours spent teaching psychopharmacology is 10. The grand mean for this category is 4.75 with the three school types averaging between four and six class hours. According to the calculations, there are no significant differences ($F = 1.74$, $p = .189$/n.s.) among optometry schools ($\bar{X} = 4.37$, $SD = 3.25$), schools of medicine ($\bar{X} = 5.47$, $SD = 2.24$) and schools of dentistry ($\bar{X} = 4.00$, $SD = 1.80$).

Central Nervous System Depressants and Stimulants

The fourth category within the questionnaire involves classroom hours spent on the CNS depressants and stimulants. No significant differences are present among schools of optometry, medicine and dentistry for hours spent in this content area ($F = 1.02$, $p = .368$/n.s.). The three school types average between seven and ten class hours on the CNS depressants and stimulants.

FIGURE 1
Total Class Hours in Pharmacology Training for Schools of Optometry, Medicine and Dentistry



Anesthetics

The hourly range on the instrument category identified as anesthetics is 10. The overall mean for the entire sample is 4.63. Although schools of optometry and medicine are not significantly different in this category ($t = 1.56$, $df = 21.0$, $p = .133$), an F-ratio of 6.91 indicates that significant differences do exist among the three groups. The comparisons between schools on hours spent teaching anesthetics show that schools of optometry require significantly less hours than schools of dentistry ($t = 3.80$, $df = 18.9$, $p = .001$).

Cardiovascular Agents

Category six within the pharmacology study questionnaire deals with cardiovascular agents. An F-ratio of 14.31 shows that significant differences exist among the school types on this category. According to the analysis, optometry schools and schools of dentistry do not differ on this category ($t = 1.24$, $df = 19.8$, $p = .229$). The mean hours for schools of medicine ($\bar{X} = 12.26$) fall above the grand mean of 9.49 and indicate that medical schools spend more time on cardiovascular agents than dental schools and schools of optometry (Med vs Den, $t = 3.74$, $df = 23.8$, $p = .001$; Med vs Opt. $t = 6.41$, $df = 20.7$, $p = .000$).

Ocular Pharmacology

The seventh category within the instrument asks for classroom hours spent on ocular pharmacology. The overall mean hours spent by the sample schools is 7.12. According to the data, schools of optometry average ($\bar{X} = 34.00$) more than the grand mean whereas medical and dental schools spend less time than the overall average ($\bar{X} = 0.63$ and 0.57 respectively). All three groups had relatively large standard deviations that indicate extensive variability.

The results of the analysis of variance (ANOVA) show that there are statistically significant differences among the groups on this category of the pharmacology study questionnaire. The comparative analyses show that optometry schools spend more hours than schools of medicine ($t = 8.97$, $df = 7.0$, $p = .000$) and schools of dentistry ($t = 8.94$, $df = 7.0$, $p = .000$) teaching ocular pharmacology to their students.

HB

337

STATE OF ALASKA
1992 LEGISLATIVE SESSION

FISCAL NOTE

BILL NO. SSHB 337

Revision Date. _____ Department Affected: Commerce & Economic Development

Title: An Act providing for the licensing of radiologic diagnostic technologists.... BRU: Occupational Licensing

Component: Administration

Sponsor: Reps. Martin and Gruenberg

Requestor: House Labor & Commerce COMPONENT SERIAL NO. 0 3 5 6

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	22.5	22.5	22.5	22.5	22.5	22.5
TRAVEL	3.4	3.4	3.4	3.4	3.4	3.4
CONTRACTUAL	30.1	10.1	10.1	10.1	10.1	10.1
SUPPLIES	1.6	1.6	1.6	1.6	1.6	1.6
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	57.6	37.6	37.6	37.6	37.6	37.6
CAPITAL						
REVENUE	95.2		75.2		75.2	

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER - GF/PR	57.6	37.6	37.6	37.6	37.6	37.6
TOTAL	57.6	37.6	37.6	37.6	37.6	37.6

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary)

SSHB 337 establishes a licensing program for radiologic diagnostic technologists and radiologic therapeutic technologists, to be administered by the department.

(Continued on the attached)

Prepared By: Jennifer Strickler Phone: 465-2144

Division: Occupational Licensing Date: 03/06/92

Approved by Commissioner: Glenn A. Olds

Agency: Commerce and Economic Development Date: 3.10.92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

CONTINUATION OF FISCAL NOTE ANALYSIS - SSHB 337

The bill requires the department to establish criteria for licensing of radiologic diagnostic technologist and radiologic therapeutic technologist, and to include providing for a licensing examination. Based on information received by the division, we have estimated that at least 300 individuals would be affected by this bill.

Licensing programs are required to share in the responsibility of covering a portion of the agency's administrative costs, as well as any anticipated costs that a program may incur. Therefore, this fiscal note is based on the following:

Personal Services $ 22.5

Based on 300 licensees, this funding will cover approximately 1% of the administrative expenses including 25% of a Licensing Examiner's position. (The 25% is based on an existing program with similar number of licensees.)

Travel 3.4

This funding will provide at least four in-state trips to conduct public hearings on regulations and to administer licensing examinations.

Contractual Services 30.1

This funding will provide for a one-time expense of developing a licensing examination (if none exists nationally). If an examination already exists, this funding would be used to contract for use of the exams. ($20.0)

This funding will also cover expenses for printing and advertising, communications, postage, a portion of the administrative overhead costs, and any other contractual services items. (10.1)

Supplies 1.6

This funding will provide daily operating supplies, such as paper, envelopes, etc..

TOTAL: $57.6

REVENUE

Since licenses would expire every other year, the revenue collected from licensing fees must be adequate to cover the costs over a two year period. Based on 300 licensees, each practitioner can be expected to pay fees of approximately $318.00 to cover costs of $95.2 in the first two years. In the third year of operation, fees could be lowered to approximately $251.00, to cover program costs, depending on the actual number of licensees.

Because of the staggered license expiration date across all licensing programs, fees from other programs would cover the costs of this program during the non-renewal years; as this program would do for other areas during a renewal year. The main objective is to ensure that program receipts collected from this program is sufficient to cover the average program costs.

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. House Bill NO. 337

Revision Date:
Title: Licensing of radiologic diagnostic & radiologic theapeutic technologists
Sponsor: Martin, Gruenberg
Requestor: Labor & Commerce

Dept. Affected Health & Social Services
BRU: State Health Services
Component: Laboratory Services
COMPONENT SERIAL NO. 0-80-40502-291

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact

Prepared by: Peter M. Nakamura, MD, MPH
Division: Public Health
Phone: (907) 465-3090
Date: 1/30/92

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services
Date:

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
OMB
Impacted Agency(ies)

(Rev 12/91)

Alaska State Legislature
HOUSE OF REPRESENTATIVES

Official Business

State Capitol
Juneau, AK 99801-1182

TO: Terry Martin
FROM: David Finkelstein
DATE: March 19, 1992
SUBJECT: HB 337, licensing of radiologic technologists

When the House Labor and Commerce Committee heard HB 337 on March 10, several issues were raised by the Administration and others which need to be addressed before the bill can be brought back before the committee. Once you have developed a CS addressing these issues, we can hold another hearing. The committee staff, Catherine Reardon, is available to provide any assistance you may need. Please call her if you have any questions.

Qualifications for Radiologic Technologist License - What type of certification is required by Sec. 08.89.010(a)(4)? Will a signed statement by the applicant be adequate, or will other jurisdictions have to provide statements that the applicant has not had a license revoked?

What courses of study exist which the Department may chose to approve? How long do they take to complete, and are they available in Alaska? What alternative training would be appropriate?

The examination must be "provided by the Department". What appropriate exams are available to the Department and does the language permit applicants to take exams given by other entities?

How can the bill be amended to allow simple or emergency X-rays to be performed in rural areas? Can a lower level of X-ray technician be created, who has less training and fewer permitted activities? What should those technicians' training, examination and activities be?

If an individual wants to be licensed as both a diagnostic and a therapeutic technologist, must that person apply separately for each license?

Display of License - How can travelling X-ray technicians comply with the requirement to post their licenses at each place of business?

Permitted Activities - Diagnostic technologists are permitted to work only under the, "specific direction of a person licensed to prescribe the examination". What does "specific direction" mean, for example, in the same office, the same room, after receiving written instructions? What does "examination" mean?

Must X-rays and radiation treatments be prescribed? The bill permits technologists to "select techniques" for the application of radiation. Doesn't the licensed practitioner prescribe the technique?

Exemptions - Does the U.S. government have standards for the training of employees who apply radiation for diagnosis or treatment? Why should federal employees be exempted?

Will dental assistants be able to conduct X-rays? If not, how will HB 337 affect the operation of dental offices?

Grounds for Impositions of Disciplinary Sanctions - How do the grounds compare to other licensed medical occupations? What does the term "unfit" mean, and is it used for other occupations?

Definitions - Does the definition of "licensed practitioner" include all medical professionals who currently take X-rays? Are nurses included, and, if not, should they be?

Why does the definition of "radiation" exclude radio waves and light? Why shouldn't ultrasounds be covered?

Effective Date

The effective date is July 1, 1992. After that date, unlicensed persons will not be permitted to use radiation. Will there be enough time for the department to write regulations, and approve courses and exams, and for current practitioners to receive licenses?

REP. TERRY MARTIN

ELECTIVE DISTRICT 13
MOUNTAIN VIEW
RUSSIAN JACK SPRINGS
NUNAKA VALLEY
ELMENDORF AFB
CREEKSIDE
EAST ANCHORAGE

HOME
[illegible]
ANCHORAGE, AK [illegible]
PHONE [illegible]

DURING SESSION
POUCH [illegible]
STATE CAPITOL [illegible]
JUNEAU, AK [illegible]
PHONE 465-[illegible]

Alaska House of Representatives

SPONSOR STATEMENT

SSHB 337

Providing for the licensing of radiologic technologists and radiologic therapeutic technologists

Diagnostic radiographic procedures are presently performed in the state of Alaska without statutory licensing. With the responsibility of shielding patients and staff from unnecessary radiation while accurately determining the correct dosage and levels of radiation, both of these occupations should require an adequate level of licensure and standards through a measurable set of qualifications.

Need for Legislation

It has been brought to my attention by Alaskan members of ARRP that there is a vacuum in our health safety certifications pertaining to the specialty of X-Ray technicians. After following up on their requests through legal services and the Health Dept., it was decided that we should act in their best interest by providing this professional certified health service to Alaskan citizens.

Current Alaska law does not reference the centralized licensing of radiologic diagnostic technologists, radiologic therapeutic technologists, or any any other occupation within the field of radiology. Interestingly, it does provide for a Board of Barbers, a Board of Real Estate Appraisers, and for the regulation of concert

promoters. Clearly, the radiological profession should be added to this chapter (AS 08.01.010).

Considering the risk involved in the process performed, as well as the necessary expertise to prevent harmful, if not fatal injury to patients and staff, other states have opted to regulate the practice to maintain safety. Currently, 27 states license radiographers which is an increase of five states since last year. These states make up 64 percent, or about two-thirds, of the U.S. population. In addition, 10 other states not including Alaska are considering legislative proposals to license radiologic professions.

At this time, the American Registry of Radiologic Technologists (ARRT), is the primary national registry for radiologic technologists and it reported 169,741 certificate holders as of January 1, 1991. The presumption is that these individuals will pass the testing procedures proposed without any problems, while the under-qualified and potentially hazardous technicians will be prevented from operating equipment and harming others.

The bottom line is that safety and precision are priorities in the profession of radiology. **HB337** establishes a tool through which negligence and potential harm will be eliminated while proficiency and education will be promoted, resulting in a standardized and regulated practice benefitting all Alaskans.

REP. TERRY MARTIN

ELECTIVE DISTRICT 13
MOUNTAIN VIEW
PUSSIAN JACK SPRINGS
NUNAKA VALLEY
ELMENDORF A F B
CREEKSIDE
EAST ANCHORAGE

HOME
3960 REKA DRIVE #6
ANCHORAGE, AK 99508
PHONE 333-6990

DURING SESSION
POUCH V
STATE CAPITOL BUILDING
JUNEAU, AK 99811
PHONE 465-4783

Alaska House of Representatives

SECTIONAL ANALYSIS

SSHB 337

Providing for the licensing of radiologic technologists and radiologic therapeutic technologists

Section 1

Amends AS 08.01.010 (Centralized Licensing) adding the regulation of radiologic technologists (AS 08.89).

Section 2

Sec. 08.89.010
Lists qualifications for radiologic technologist licensing.

Sec. 08.89.020
Requires display of the license.

Sec. 08.89.030
Establishes permitted activities such as selection of techniques, positioning of patients, and the application of radiation for diagnostic purposes by radiologic diagnostic and therapeutic technologist

Sec. 08.89.040
Lists those individuals exempted from the regulation as: students attending a college of medicine or any other school where elements of radiology are taught (e.g., chiropractic, dental, podiatry) in which the student is under direct supervision by a licensed practitioner,

licensed practitioners, dental hygienists in dental practice and employees of the United States government who apply radiation for diagnosis or treatment.

Sec. 08.89.050
Provides disciplinary sanctions for licensees found to have: illegally acquired their license, fraudulently practiced radiologic service, been convicted of a felony, continued to practice when unfit through incompetence, drug use, or physical/mental disability, failed to comply with the regulations or shared the license.

Sec. 08.89.060
Prohibits non-licensed persons from applying radiation for diagnostic or therapeutic purposes or fraudulently using the title. Violations can result in a class B misdemeanor.

Sec. 08.89.900
Defines all scientific and medically related references and words.

Section 3

Requests the DCED to issue a license no later than June 30, 1993 for those qualifying under this chapter who provide certification that they have practiced the profession for five years before the effective date and have satisfied the requirements and passed the necessary examination.

Section 4

Effective date of July 1, 1992.

7-LS1354\G
Luckhaupt
4/27/92

CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 337 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES MARTIN, Gruenberg

A BILL

FOR AN ACT ENTITLED

"An Act regulating the practice of radiologic technology; and providing for an effective date."

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

* Section 1. AS 08.01.010 is amended by adding a new paragraph to read:

(33) regulation of radiologic technologists and technicians (AS 08.89).

* Sec. 2. AS 08 is amended by adding a new chapter to read:

CHAPTER 89. RADIOLOGIC TECHNOLOGY.

Sec. 08.89.010. QUALIFICATIONS FOR RADIOLOGIC TECHNOLOGIST LICENSE. The department shall issue a license to an individual as a radiologic technologist who

(1) is 18 years of age or older;

(2) applies on a form provided by the department;

(3) pays an application fee prescribed by the department under AS 08.01.065;

(4) provides certification to the department that the individual

(A) has not engaged in conduct that is a ground for imposing discipline

under AS 08.89.080;

(B) has not voluntarily surrendered a license or had a license suspended or revoked in another jurisdiction for grounds substantially similar to one of those specified in AS 08.89.080;

(C) has completed a course of study in radiologic technology approved by the department; and

(D) has

(i) passed an examination provided by the department for licensure as a radiologic technologist or an examination provided by a national certifying radiologic technologist organization approved by the department for licensing as a radiologic technologist; or

(ii) been licensed by another jurisdiction as a radiologic technologist and is at the time of application licensed by the other jurisdiction, if the license was issued on the basis of an examination reasonably equivalent to the examination administered by the department under this section.

Sec. 08.89.020. QUALIFICATIONS FOR RADIOLOGIC TECHNICIAN CERTIFICATE. An individual who does not meet the qualifications established by the department for licensure as a radiologic technologist may be certified by the department as a radiologic technician if the individual

(1) meets the requirements for licensure as a radiologic technologist under AS 08.89.010(1) - (4)(A) and (B);

(2) has demonstrated to the satisfaction of the department that the individual is capable of performing diagnostic X-ray examinations on specific body parts without endangering the public health and safety; in determining if the individual has demonstrated the capacity of performing diagnostic X-ray examinations, the department may require the applicant to have satisfactorily completed

(A) an educational program approved or accepted by the department;

(B) a training program approved or accepted by the department;

(C) an examination approved or accepted by the department; or

(D) a combination of (A) - (C) of this paragraph.

Sec. 08.89.030. RENEWALS. A license issued under AS 08.89.010, or a certificate

issued under AS 08.89.020 expires annually on a date set by the department and may be renewed upon payment of the required fee and the submission of evidence satisfactory to the department that a licensed radiologic technologist or certified radiologic technician has met the continuing education requirements set by the department, has demonstrated continued practical professional competence, and has not committed an act that is a ground for discipline under AS 08.89.080.

Sec. 08.89.040. SPECIAL RADIOLOGIC TECHNICIAN PERMIT. (a) The department may issue a special radiologic technician permit to an individual not qualified for licensure as a radiologic technologist or certification as a radiologic technician to apply radiation to specific parts of the human body for diagnostic purposes under the direct supervision of a person licensed to prescribe the application if the department finds that the individual should be granted a special permit because of regional hardship or emergency condition

(b) A special radiologic technician permit issued under (a) of this section is valid for a term set by the department but not exceeding one year.

(c) Only one special radiologic technician permit under (a) of this section may be issued to an individual.

(d) An individual issued a special radiologic technician permit may perform all of the activities of a certified radiologic technician as permitted by the special permit.

Sec. 08.89.050. DISPLAY OF LICENSE OR CERTIFICATE. (a) An individual licensed as a radiologic technologist or certified as a radiologic technician in the state shall display the license or certificate in a prominent place at each place of business of the individual.

(b) If an individual licensed as a radiologic technologist or certified as a radiologic technician has more than one place of business, the department shall, on request and payment of a fee, issue a duplicate license or certificate for each place of business of the individual.

Sec. 08.89.060. PERMITTED ACTIVITIES. (a) A licensed radiologic technologist may select techniques, position patients, and apply radiation to persons for diagnostic or therapeutic purposes under the general supervision of a person licensed to prescribe the application.

(b) A certified radiologic technician may select techniques, position patients, and apply radiation to specific parts of the human body for diagnostic purposes under the indirect supervision of a person licensed to prescribe the treatment.

Sec. 08.89.070. EXEMPTIONS. The provisions of this chapter do not apply to

(1) a student attending a school or college of medicine, osteopathy, podiatry,

dentistry, dental hygiene, chiropractic, or radiation technology if, at the time of application, the unlicensed student is under the direct supervision of a licensed practitioner who is licensed to prescribe the examination or treatment;

(2) a licensed practitioner;

(3) a dental hygienist licensed under AS 08.32, applying radiation to a person solely for the exposure of radiographs for dental diagnosis while under the direct or indirect supervision of a dentist licensed under AS 08.36;

(4) an employee of the United States government who as part of the employee's duties applies radiation to a person for purposes of diagnosis or treatment.

Sec. 08.89.080. GROUNDS FOR DISCIPLINE, SUSPENSION, OR REVOCATION OF LICENSE, CERTIFICATE, OR PERMIT. The department may impose a disciplinary sanction on an individual holding a license, certificate, or permit under this chapter if the department finds that the individual

(1) secured a license, certificate, or permit through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted of a felony or other crime that affects the individual's ability to continue to practice competently and safely;

(5) intentionally or negligently engaged in or permitted the performance of client care by persons under the individual's supervision that does not conform to minimum professional standards regardless of whether actual injury to the client occurred;

(6) failed to comply with this chapter, with a regulation adopted under this chapter, or with an order of the department;

(7) continued to practice after becoming unfit due to

(A) professional incompetence;

(B) failure to keep informed of current professional practices;

(C) addiction to or severe dependency on alcohol or other drugs that impairs the ability to practice safely;

(D) physical or mental disability;

(8) engaged in lewd or immoral conduct in connection with the delivery of professional service to clients.

Sec. 08.89.090. DISCIPLINARY SANCTIONS. (a) When it finds that an individual holding a license, certificate, or permit is guilty of an offense under AS 08.89.080, the department, in addition to the powers provided in AS 08.01.075, may impose the following sanctions singly or in combination:

(1) permanently revoke a license, certificate, or permit to practice;

(2) suspend a license, certificate, or permit for a determinate period of time;

(3) censure an individual holding a license, certificate, or permit;

(4) issue a letter of reprimand;

(5) place an individual holding a license, certificate, or permit on probationary status and require the individual to

(A) report regularly to the department upon matters involving the basis of probation;

(B) limit practice to those areas prescribed;

(C) continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need improvement;

(6) impose limitations or conditions on the practice of an individual holding a license, certificate, or permit.

(b) The department may withdraw probationary status if it finds that the deficiencies that required the sanction have been remedied.

(c) The department may summarily suspend a license, certificate, or permit before final hearing or during the appeals process if the department finds that the individual holding a license, certificate, or permit poses a clear and immediate danger to the public health and safety if the individual continues to practice. An individual whose license, certificate, or permit is suspended under this subsection shall be entitled to a hearing by the department no later than seven days after the effective date of the order. After a hearing, the individual may appeal the suspension to the superior court.

(d) The department may reinstate a certificate or permit that has been suspended or revoked if the department finds after a hearing that the applicant is able to practice with reasonable skill and safety.