Approved 3-4-86
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./~~p.m.~~ on February 27, 1986 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Norman Furse, Revisor's Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
Jerry Slaughter, Kansas Medical Society
Dr. Frank Griffith, Opthalmology, Salina
Dr. Albert N. Lemoine, Jr., Chairman of Dept. of Opthalmology, KUMC, 1950-1980.
Dr. Dee Bell, President, Kansas Medical Society, Department of Opthalmology

SB-651 - Defining the practice of optometry and establishing continuing education requirements

Frank H. Griffith, M.D. testified and presented written testimony opposing SB-651. Attachment I Dr. Griffith stated that his was a unique position in that he first qualified as an optometrist and later returned to medical school and obtained his medical degree in Opthalmology. Dr. Griffith testified that as an optometrist he was not trained to treat eye diseases, and it is difficult to separate mild eye disease from serious disease. At this time every citizen in the state of Kansas who has an eye disease has a guarantee that he will be treated by a physician. This would not be the case if SB-651 were passed.

Albert N. Lemoine, Jr., M.D. testified and pressented written testimony opposing SB-651. Attachment II Dr. Lemoine testified that he supported the optometrists in obtaining the use of diagnostic drugs but he was opposed to a wider scope of practice for them. He made the following points: (1) Dr. Lemoine felt that he could agree that there has been a definite improvement in optometric education in the last decase. Intellectual competence is certainly adequate but it is a matter of educational strengths. (2) The perception of the training of medical students and the training of optometrists is quite diverse. The assumption that any number of academic hours or tests of pharmacology will determine the competence to make a definitive diagnosis of disease and the use of the proper drugs for topical therapy is false. (3) The important thing in treating a patient is to make a diagnosis and then treat the patient. Direct patient exposure cannot be compared to books, seminars and observation. (4) What is the danger to the public? The real danger is vision loss or blindness. (5) Medicine is not a hard science, it is a constantly changing science and there are still great gaps in knowledge.

Dr. Dee Bell made the following statements opposing SB-651. (1) Optometric therapeutic drug legislation has been introduced 39 times. It has been passed 7 times. There is no proven track record. (2) There are 15 optometric schools in the U.S. Only one state with an optometric school has passed this legislation. The legislation has been considered in Pennsylvania four times and it has been turned down four times. She read three sentences from a committee report. Attachment III The committee has not been presented with any credible evidence which indicates that the current limitations upon the use of therapeutic drugs by optometrists are in any way impairing the visual health of the people of Pennsylvania. The committee received no evidence of any substantial public need for this expanded scope of practice, nor did the committee receive any substantial evidence of increased public benefit which would result from such expanded scope of practice. Dr. Bell

presented the committee with handouts reporting on the typical problems encountered by George W. Weinstein, M.D., Professor & Chairman of the Department of Opthamology of West Virginia University School of Medicine. Attachment IV

In answer to a question from Senator Salisbury Dr. Bell stated that there had been in effect since the mid 1970s a committee called the M.D., Optometric Committee which is under the auspices of the Kansas Medical Society and the Optometric Society. There was and has been discussion through the years in that committee. There was no attempt to have this issue placed before the committee by Optometry. The Medical Society found out about this bill in November and asked that it be put on a discussion at a meeting already scheduled in early December and were told that at that time there was no bill to discuss. After being asked to hold discussions they requested two considerations, the copy of the final bill as it would be introduced and some time. The final bill was received February 22, 1986.

In further questioning it was brought out that opthamologists had copies of the bill as they were showing it to their Senators prior to this date.

Senator Riley requested a chart showing what the general practioner gets in training as compared to what an optometrist gets. Also, after graduation, what is the continuing education of general practioners as compared with optometrists. Dr. Lemoine verbally detailed the various educational methods.

Chairman Ehrlich requested Dr. Dee Bell present written testimony on her presentation and that Senator Riley's request for a chart be honored.

Meeting adjourned at 11:05 a.m.

Written testimony by Dr. Dee Bell submitted day after testimony. Attachment V

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-27-86

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Jim Yonally, Overland Park		Kan. Optom. Assoc.
Gary Robbins,		Kan " "
Terry Hawks, OD		" " "
MARK SGLENN O.D.	RUSSELL, KAN	Kans. Optom. Assoc.
Dale Isely	Topeka	Self
Sue Brunner	Holton	Self
Phil Anderson,	Topeka	BUDGET DIVISION
Marilyn Bradt	Lawrence	KINH
Ken Schafermeyer	Topeka	KS Pharmacists Assoc.
Verne Claussen	Wamego	KOA
Terri Rosselot	Topeka	KSNA
Randel L. Baylor MD	Hutchinson	Kansas State Ophth. Society
FRAPPIER MD	HAYS	KS ST OPHTH Soc.
Robert A. Summers OD	Topeka	
Pete Brungardt OD	Salina	Ks Optometric Assoc
Bob Henderson OD	Wichita	" " "
Marvin E. Wallace OD	Olathe	" " "
Jack Rickerson	Topeka	SRS
RUTH Humbert	Topeka	KSNA
Joni Koch	Topeka	KSNA
HUGH R BEESON	ARKANSAS CITY	O.A.K.
C. T. McCoy M.D.	HUTCHINSON	KS. OPH. SOC.
K. WRIGHT HENDRICKS, MD	KC, KS	KS OPHTH SOC.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-27-86

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Henry T. Iseri, MD Kansas City, Ks	Kansas Ophthalmological Society
Timothy B. Cavanaugh	KU Med - Ophthalmology
Larry E. Harris, OD	
Donald E. Tarwater D.O. Wichita, Ks.	Ks. State Opthal. Soc.
Harold E. Kiefer	KAOM
Bradford A. Prokop M.D	Ks State Ophthal Society
Ron Heir	" " " "
Al [illegible]	
Frank H Griffith	Ks State Ophthalmology Society
Don Bell O P Ks	" " " "
Perry M. Achuff Great Bend	" "
W.E. Thompson - Wichita	" " " "
Donald E Beahm MD Great Bend	Ks Counsellor to Am Academy of Ophthalmology
Dona Harriott, OD Topeka	Kansas Optometric Assoc
Mark Hamm Burlington	" " "
Suzanne M Collins	wife of opthalmologist

2-27-86

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TESTIMONY ON SB-651

"Optometric Therapeutic Bill"

Mr. Chairman, Members of the Committee, Ladies and Gentlemen:

My name is Frank H. Griffith. I am a medical doctor specializing in eye disease and have practiced in Salina, Kansas, since 1978. I feel that I have a somewhat unique perspective to offer regarding SB-651. I have been a licensed optometrist in the state of Kansas and was also an instructor for two years on the faculty of the University of Houston College of Optometry. My Doctor of Optometry degree was obtained in 1969, two years prior to the start of my medical education. I graduated from the University of Texas Medical School at San Antonio, Texas, and took my ophthalmology residency at the University of Kansas Medical Center.

I am a Diplomate of the National Board of Examiners in Optometry; I am Board certified by the American Board of Ophthalmology and I am a Fellow in the American Academy of Ophthalmology. I have a clinical faculty appointment as a Preceptor in the Department of Surgery of the University of Kansas School of Medicine--Wichita.

As you can see from my preceeding statement, I have a double background both in optometry and ophthalmology.

I have come before this Committee to voice opposition to the proposed expansion of optometric practice contained in SB-651. The proposed Bill would allow optometrists to use topical therapeutic drugs; perform surgical removal of foreign bodies that are not intraocular; and specifically remove the prohibition against surgery by optometrists.

As an optometrist, I was not trained to treat eye diseases; current optometric graduages are <u>not</u> trained to treat eye disease.

During my four years of optometric training, I examined a total of approximately 300 patient's eyes; most of them were normal or only required glasses or contact lenses. I only saw a few eye diseases and these were referred for final diagnosis and treatment. However, during my medical training and ophthalmology residency, I spent extensive time periods with repetitive exposure to thousands of sick patients with sick eyes. The medical and surgical management of these patients were under the direct supervision of qualified physicians and surgeons.

Optometrists are trying to equate their clinical training as being equivalent to a dentist's clinical training. However, dentists and podiatrists use therapeutic drugs only after both classroom and clinically supervised experience with their use. My optometric training had absolutely <u>no</u> supervised treatment of any type of ocular disease. Yet many of my former optometric classmates and students are here infront of this Committee asking for your approval to treat eye disease with medication and surgery even though they have no clinical experience treating eye disease.

Attachment I
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Attachment I

I

I can certainly appreciate the desire by optometrists to treat eye disease. That is precisely the reason why I went to medical school. Approximately 200 other optometrists have also gone on to medical school to obtain the proper education necessary to treat diseases.

As an optometrist, I felt that I was equal to the task of treating eye disease and felt that medical school and residency were redundant to my optometric education. Unfortunately, I was wrong. I found there is a vast body of general medical knowledge that is used on a day to day basis in my ophthalmology practice. Because this knowledge is unknown to the optometrist, he does not realize it exists, or even more important, that it may be crucial to treating disease.

This Bill takes a very narrow view of medical eye care. It focuses on treatment of the eye as an isolated organ, to the exclusion of the rest of the body systems. A further assumption is made that treatment with topical drugs is somehow different or separate from other forms of treatment. Some topical eye drops can have potent side effects that may require immediate treatment to reverse their effects. Optometrists make no claim to have any general medical training. It is not in the best interests of our citizens to have potent medications prescribed by non-medical practicioners who will be unable to detect, diagnose, and treat side effects.

It might be argued that the treatment of some eye problems are sufficiently simple to preclude the requirement for a complete medical education. However, there is the question of whether or not one can separate the treatment of "mild" eye disease from "serious" eye disease. Theoretically, this concept has some appeal, but it assumes that the boundary between simple and complex is readily apparent and sharply defined. This boundary is very often ill defined and a "simple" eye condition can rapidly deteriorate into a sight-threatening problem. It does take all the years of medical training to prepare one to make proper judgements about the potential severity of an eye problem and institute proper therapy. Optometrists do not have the clinical experience necessary to make the distinction of which cases they should and which cases they should not try to treat. It is as important to know when not to treat as it is to know when to treat. It is not satisfactory to try topical medications first, and then wait and if the patient does not get better, then refer him for more definitive and extensive treatment. This is not fair to you, your constituents as patients, or the final treating physician.

At this time, every citizen in the state of Kansas who has an eye disease has a guarantee that he will be treated by a physician. The eyesight of the citizens of Kansas is too important to risk for the benefit of a few optometrists who wish to treat eye disease without the proper medical education.

The proponents of this Bill state that eye care will be made cheaper and more available to Kansans. However, there are no patients that are not within two hours driving time from an ophthalmologist's care in Kansas or an adjacent state. This also ignores the presence of 1800 primary care physicians in the towns and cities across Kansas. Therefore, optometrists are not more accessible than existing family physicians, internists, or pediatricians. These physicians treat common eye problems and readily refer more difficult problems to an ophthalmologist. Most importantly, they are trained in general medicine and are prepared to responsibly handle all the potential side effects of these medications.

Allowing optometrists to treat with drugs will not save Kansans money. Surveys have found that optometrists have generated almost twice as many eyeglass prescriptions from the same number of patients examined (Medical Economics 1981). In January, 1986, a telephone survey of optometric and ophthalmologic charges for routine eye exams were done in the Salina, Hays, Wichita, and Johnson County areas. It is interesting to note that the fees charged were comparable and in several instances, the optometric fees were higher than the ophthalmologist charges even without the use of therapeutic drugs. There is absolutely no documented evidence that expanding the role of optometry to include the use of drugs and surgery is cost effective. The American Academy of Ophthalmology is introducing a National Eye Care Project due to start in Kansas on March 31, 1986. This program aids Kansans over 65 who can least afford medical care. Free treatment of their eye disease will be provided if these patients do not have any insurance.

This Bill will cause further confusion among the public by the creation of two types of optometrists--"treating" and "nontreating". A patient could go to a "nontreating" optometrist, be referred to a "treating" optometrist, and ultimately be referred to an ophthalmologist for final treatment. Services would be duplicated and the patient would receive a charge from each practitioner. This is not cost effective care.

Any time a profession expands its scope of practice, their malpractice costs rise after a short grace period. These higher malpractice costs will be passed on to their patients. Kansas optometrists are included in the Health Care Stabilization Fund and increased optometric malpractice claims will further strain the nearly depleted fund. Optometrists currently provide Kansans with a valuable service in the prescription and dispensing of glasses and contact lenses. There is no documented need to expand their services.

Ophthalmology's concern is that Kansans will continue to receive care from those who are best qualified by education and clinical training to precisely diagnose and properly treat eye disease as well as follow a patient's disease through the best possible recovery. This law would permit delay in diagnosis, offer the patient false reassurances, and could cause loss of vision. This is not an economic turf battle but concerns the maintenance of quality eye care for the citizens of Kansas. Do not allow political pressure to provide a short cut to education. Simply because an issue has been raised does not make it right nor does it require a compromise. This is an untried area and other states do not have a long enough track record to document the safety of allowing optometrists to treat eye disease. Do not let the citizens of Kansas have their eyesight placed at risk by an unproven practice of allowing non-medical practicioners to treat eye disease. Dr. George Weinstein has testified before the West Virginia Legislature of at least 40 cases of optometric mismanagement, some of which involved life threatening conditions such as cancers of the eye and eyelids. Other cases resulted in permanent loss of vision. Obviously, there is no truth to the claim that there have been no problems with diagnostic and therapeutic drugs used by optometrists in West Virginia. Optometry may point to a number of instances in which problems arise during treatment of eye disease by ophthalmologists. I feel badly for those patients but this simply points out that treatment of eye disease can be difficult even for ophthalmologists. How can optometrists hope to treat eye disease with a brief afterthought course in disease treatment.

Consider what you would do for your family. If you do not believe that a few additional hours of training in pharmacology will qualify a person with only six years of non-medical education to practice medicine and surgery, then vote against this bill. It will not make eye care better. It will not make eye care cheaper. It could be dangerous. This Bill is not worth the risk of the sight of even one Kansan. Weigh my testimony and if you agree, please vote against this Bill. Thank you for your time and attention.

Sincerely,

Frank H Griffith OD, MD

Frank H. Griffith, O.D., M.D.

FHG:jmg

Chairman Ehrlich and members of the Senate Public Health and Welfare Committee. My name is Albert N. Lemoine, Jr. I am a licensed M.D. in the State of Kansas and Missouri, certified by the American Board of Ophthalmology and Fellow of the American College of Surgeons.

I have been a full-time faculty member and Professor of Ophthalmology at the University of Kansas School of Medicine (Kansas City) since 1950 and was Chairman of the Department of Ophthalmology at KUMC from 1950 to 1980.

I have taught in seven schools of Optometry and since 1977 have held the rank of Adjunct Professor at the Southern California College of Optometry.

In 1975 the first optometric residency program in the Veterans Hospital system was established at the Kansas City Veteran's Administration Medical Center as the result of a joint venture of the Illinois College of Optometry (Chicago) and the University of Kansas School of Medicine (KC).

I have supported and continue to support optometrists' use of drugs for diagnostic purposes in over 29 states, the latest on February 16, 1986 in Connecticut. I was one of the primary proponents for the Kansas Diagnostic Drug Bill in 1978.

I am opposed to optometrists or any other health care providers being given the legal right to prescribe drugs for therapeutic purposes or perform surgery to treat eye diseases until their educational experiences include the direct management of patients under adequate supervision.

The proposed changes in the Optometric Practice Act under Senate Bill 651 has four significant changes:

I. The use of topical pharmacological agents to treat diseases of the eyes and their adnexae.

II. The removal of foreign bodies that are not intraocular.

III. The repeal of the prohibition on optometrists doing surgery.

IV. The examination of optometrists in pharmacology as a significant criteria for competence in the diagnosis and treatment of ocular disease.

I. My objection to the proposed change is two-fold:

A. The assumption that the optometric educational process prepares the optometrists to make a definitive diagnosis for therapy.

B. The assumption that any number of academic hours or tests of pharmacology will determine the competence to make a definitive diagnosis of disease and the use of the proper drugs for topical therapy.

Attachment II
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Attachment II

II. Objection to proposed change -- removal of foreign bodies:

At this time there is no optometry school in the country that permits the optometrists to perform surgery. One cannot develop surgical skills from books or observation -- only surgery under adequate supervision provides competence, unless one accepts learning the skill without supervision in private practice.

III. The repeal of the prohibition of surgery would in effect permit an optometrist to do any surgery except intraocular as stated in II. It is probably necessary to repeal this section of the present optometric act in order to remove foreign bodies, which is a surgical procedure.

The dangers to the public if optometrists are permitted to use topical drugs for therapeutic purposes and remove foreign bodies as I perceive them are:

A. Not death of a patient which is remote. Serious general health problems or morbidity would be slight. The only topical drug that might present a problem would be Timoptic to treat glaucoma.

B. The danger would be reduced vision or blindness due to improper or inadequate treatment of ocular disease -- in particular, corneal diseases, iritis/uveitis and glaucoma. From nearly daily contact with optometric residents at the Kansas City Veterans Hospital and teaching in optometry school, I am certain that there is an inadequate educational experience in the supervised management of patients with ocular disease in the present schools of optometry. This in no way reflects on the intellectual ability of the optometry student or optometrist, but rather the disease distribution of the patient population being examined and treated.

For me, one of the greatest problems in legislation that permits the optometrist to use drugs for therapeutic purposes or perform surgery, is the role assigned to pharmacology and pharmaceutical agents. For surgery, pharmacology is of no significance. The use of the terms diagnostic or therapeutical pharmaceutical agents is confusing. Any pharmaceutical agent or drug may be used for either purpose. A diagnostic pharmaceutical agent or drug means that it is used once or twice in an office or hospital setting to either aid in the diagnosis (e.g. dilate the pupil to see the back of the eye better) or make a diagnosis (e.g. Tensilon or Prostigmin in Myasthenia gravis). A therapeutic use of the drug usually means the patient will be given the responsibility to use the drug over a period of time (e.g. eye drops or injection of insulin).

The role of an understanding of the pharmacology of drugs in their use for therapy is rather insignificant. An understanding of pharmacology does not aid in making a diagnosis. Most of the information learned in pharmacology concerns the actions of drugs in the normal human or animal, and not how the drugs react when an organ or the body is diseased.

Another issue that is usually considered in "therapeutic drug" legislation is the number of academic hours of pharmacology taught in Optometry Schools, Dental Schools and Medical Schools. I am certain that any attempt to correlate academic hours of an optometry school and a medical school would be meaningless. If one takes the hours of pharmacology in a medical school catalogue, this would reflect only that experience, usually in the second year of medical education, when the student studies Pharmacology, Toxicology and Therapeutics. (The catalogue of the University of Kansas, School of Medicine, 1985-86 lists 174 total hours of lectures, conferences and laboratory). This in no way reflects the hours spent the last two years of medical school and residency training when clinical pharmacology is studied in nearly all patients seen being treated for disease with drugs. A reasonable estimate is that a physician obtaining an M.D. degree will have at least three to four times the number of hours of pharmacology as listed in the catalogue.

Because of the above facts and reasons, I cannot support Senate Bill 651 and believe that its passage would be to the public's disadvantage. At this point in time, the formal educational experience of the optometrist does not involve enough personal supervised care of patients with eye disease to make a definitive diagnosis for therapy or surgery. This is no reflection on the intellectual ability of the optometric students or optometrists, but rather the educational experience. It is important to realize that the above opinions apply not only to optometrists but to all health care providers, including M.D.'s and D.O.'s. We can legislate rights but it is extremely difficult to legislate competence, especially in medicine which is an emperical rather than an exact science.

I want to thank you for your time and attention to this presentation, and hope that it will give you my perspective on this difficult issue that you must decide.

THANK YOU.

OPTOMETRIC BOARD SUNSET REPORT

Pennsylvania

Introduction

Act No. 142 of 1981, P.L. 508, 71 P.S. §1795.1 et seq., known as the Sunset Act, establishes a system for the audit and evaluation of state agencies in the Commonwealth of Pennsylvania. Pursuant to the Sunset Act, a given state agency is scheduled for termination at the end of a particular calendar year. Prior to the end of that year, the agency undergoes a performance audit, conducted by the Legislative Budget and Finance Committee. The audit report and recommendations are provided to a designated standing committee of the General Assembly, which is then responsible for reviewing the audit, conducting public hearings, and making a report to the General Assembly on or before the first session day of September of the year in which the agency is scheduled for termination. After receiving the report from the standing committee, the General Assembly may either act to reestablish or continue the agency, or permit the scheduled termination of the agency to take effect.

Pursuant to Act 142, the State Board of Optometrical Examiners is scheduled for termination on December 31, 1985. The responsibility for reviewing and evaluating the State Board of Optometrical Examiners was assigned by the Leadership Committee to the Consumer Affairs Committee of the State House of Representatives. Pursuant to that assignment, the Consumer Affairs Committee has received and reviewed the Sunset Performance Audit of the State Board of Optometrical Examiners, as prepared by the Legislative Budget and Finance Committee, dated February, 1985. Beginning in March of 1985, the Committee conducted four public hearings on six separate days in

Attachment III
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Attachment III

where private citizens, acting on their own behalf, were able to secure the successful criminal prosecution of persons engaged in the unlicensed practice of optometry. Thus the main problem would not appear to be the current law which requires that persons engaged in the unlicensed practice of optometry be criminally, rather than administratively, prosecuted, but rather bureaucratic neglect and ineptness involving the entire issue. While the Committee has no desire to see the board become a kangaroo court, passing judgement on the basis of investigations and prosecutions which could not pass muster in the independent judicial system, it does recognize the difficulty experienced by the board in pursuing investigations and prosecutions throughout the state. Therefore, the Committee determines that the board should be authorized to administratively enjoin and prosecute the unlicensed practice of optometry. The Committee further determines that the Optometric Practice Act should be amended to provide the board with the investigators and attorneys necessary to prosecute the unlicensed practice of optometry, and that the board be given authority to level fees upon licensed optometrists sufficient to pay for this personnel.

The second area of the "scope of practice" which was reviewed by the Committee concerns the use of pharmaceutical agents by optometrists in the diagnosis and treatment of conditions and diseases of the eye. In Pennsylvania, optometrists are not considered to be physicians and have historically not been authorized to engage in the practice of medicine. However, in 1974, the legislature passed the diagnostic and pharmaceutical act, which authorized optometrists in Pennsylvania to use certain diagnostic drugs as approved by the Secretary of Health. These drugs enable an optometrist to diagnose the presence of certain diseases of the eye, such as

cataracts and glaucoma. The present Optometric Act authorizes a licensed optometrist to use any and all means or methods to examine and diagnose conditions of the human visual system, while limiting the actual treatment of the conditions of the human visual system to any and all means or methods except for drugs or surgery. Many witnesses appeared at the hearings held by the Committee and urged that these definitions be changed, so that optometrists would be permitted to use therapeutic drugs in the treatment of conditions of the human visual system.

It is evident to the Committee that this subject is very controversial, and raises a great deal of emotion on both sides of the issue. The Committee does not believe that its function in this sunset review process is to become embroiled in this controversy. However, based upon the information made available to the Committee, several points should be made. First, the Committee has not been presented with any credible evidence which indicates that the current limitations upon the use of therapeutic drugs by optometrists are in any way impairing the visual health of the people of Pennsylvania. The Committee received no evidence of any substantial public need for this expanded scope of practice, nor did it receive any substantial evidence of any increased public benefit which would result from such an expanded scope of practice. Second, it is clear that many optometrists who are currently licensed in Pennsylvania are not in any way qualified to use therapeutic drugs in the course of their practice. Many optometrists presently licensed received their education at a time when very little in this area was taught in the schools of optometry. Third, while the use of therapeutic drugs, and the related studies such as biology, physiology, pharmacology, and clinical experience, are presently receiving more emphasis

in optometric education than they have at times in the past, the Committee is not convinced that even optometrists who have recently attended an optometric college have received sufficient education to be authorized to use therapeutic drugs solely at their discretion. Neither is the Committee convinced that such authorization would not have an adverse impact upon the health and safety of eye care patients in Pennsylvania.

Therefore, the Committee has determined that a special expert advisory panel consisting of two licensed optometrists, two physicians certified as opthalmologists, and one physician certified as a pharmacologist should be created. The purpose of this panel would be to review the issue of the use by optometrists of diagnostic pharmaceutical agents which have not been approved by the Secretary of Health, and to report to the legislature and to the Optometrical Board its findings and recommendations. The Committee further determines that the special advisory panel should also be authorized to review the question of the scope of the practice of optometry as it relates to the fitting of contact lenses, and that two persons engaged in the occupation of fitting contact lenses should be members of the board for the purposes of such deliberations. Finally, the Committee determines that the membership of the State Board of Optometrical Examiners should be expanded to include a certified opthalmologist. The Committee feels that the expertise of a physician would be very valuable to the board in a number of areas, including the clinical testing of candidates for licensure as optometrists in the area of competence in the use of diagnostic and pharmaceutical agents.

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March 18, 1985

West Virginia University

George W. Weinstein, M.D.
Professor and Chairman

Oculoplastic Surgery
John V. Linberg, M.D.

Corneal and Inflammatory Diseases, Glaucoma
Ivan R. Schwab, M.D.

Retinal and Vitreous Disorders
Matthew E. Farber, M.D.

Laboratory

Pharmacology
Brenda K. Colasanti, Ph.D.

Visual Physiology
J. Vernon Odom, Ph.D.
Gung-Mei Chao, Ph.D.

Retinal Function
Robert R. Hobson
Nancy Taylor

Clinic:

Ophthalmic Photography
Allan R. Jones

Clinic Nurse
Jean Lofflin, R.N.

Ophthalmic Technicians
Michelle Michael
Nancy Cronin
Janet Grasso

Orthoptics
Margaret Hodous

Office Manager
Tammy Miller

Staff Writer
Gail Adams

Members of the Health, Education
and Welfare Committee
House of Representatives
Legislature, State of Rhode Island

Dear Members of the Committee:

I am George W. Weinstein, M.D., Professor and Chairman of the Department of Ophthalmology of the West Virginia University School of Medicine. I came to West Virginia in 1980, 4 years after legislation had been enacted in that state permitting optometrists to use eyedrops for both diagnostic and therapeutic purposes. In that time, I have had the opportunity to see first hand a number of patients who have been misdiagnosed and mistreated by optometrists, contrary to the claim of some that there have been no such problems in our state. Also, I am personally familiar with three cases of optometric malpractice, where patients have brought suit against various optometrists, including one against the current state president of the West Virginia Optometric Association for failure to diagnose or appropriately refer a patient for medical care.

I wish to review briefly four cases typical of the problems I have witnessed:

A twenty year old man suffered an injury to his left eye while hammering on a nail. He went to an optometrist who treated him with eyedrops and telling the patient that with these antibiotics the damage done to the eye would heal. Twenty-four hours later the optometrist noted pus developing inside the eye. The patient eventually made his way to our hospital. We found a full thickness cut in the cornea of the eye and evidence of active infection within the eye. The patient required surgery to close the wound in the eye together with intravenous antibiotics. Fortunately, his recovery of vision was good.

On two occasions, a young woman was seen by optometrists and treated for red eye with blurred vision with antibiotic ointments containing cortisone. In both of these cases, treatment was continued for many weeks before each of these patients came to our clinic, where we made the diagnosis of herpes infection of the cornea. I should point out that in this disease, antibiotics are ineffective and cortisone makes the condition worse. Special diagnostic tests were instituted, and appropriate treatment was given. In each case, the patients recovered most, but not all their vision.

A middle aged man went to an optometrist because of decreased vision. He was told that there was a problem with circulation. Eventually, he sought ophthalmological care and was referred to our hospital. Our tests showed a very large tumor of the pituitary gland of the brain, growing upward and compressing the optic nerve.

A forty year old woman went to an optometrist because of blurred vision in the left eye. She was told that she had a cataract and was given a new pair of glasses although these did not improve her vision. Over subsequent months, her vision continued to decrease. The patient thought that her cataract was "ripening". Eventually she went to see an ophthalmologist who referred to us here. We discovered a tear in the retina with a large detachment of the retina. She required surgery for repair. Her vision returned only partially. The long delay before treatment almost certainly cost her a more complete return of vision in that eye.

Also, I have had the opportunity to review legal testimony concerning two other instances of optometric mismanagement. In one, an elderly woman was followed by an optometrist for two years with a diagnosis of "granulated eyelid". Antibiotic ointment was given as treatment, but because the condition seemed to worsen, the patient eventually sought the care of an ophthalmologist. The "granulated eyelid" condition proved to be cancer of the lower lid requiring extensive excision. In another case, a young man who had been fitted for contact lenses by two optometrists practicing together noted marked loss of vision in one eye. He went back to the optometrists for evaluation, and on examination they failed to conclude that the blurred vision was due to conjunctivitis (pink eye). While these optometrists checked the man's vision in each eye, they did not even take the trouble to perform a refraction, a test with which all optometrists are familiar and for which they are appropriately trained. They did not even use the simple expedient of checking the patient's vision with him looking through a pinhold occluder, a device that would improve vision if the condition were nothing other than a focusing problem. The patient eventually saw an ophthalmologist who discovered a retinal detachment. This required surgical treatment.

The cases which I have cited above are but a sample of the kinds of occurences which we have seen in our clinic at the University Hospital. I am aware of at least 36 other people in our state who have had similar unpleasant experiences. Some of these resulted in nothing more than inconvenience and increased expense for eye care that could have been provided much more simply, accurately, and economically by an ophthalmologist. In other cases, these patients had permanent loss of vision, and even life threatening conditions, such as eyelid tumors and cancer, misdiagnosed or mistreated. Obviously, there is no truth to the claim that "there have been no problems with diagnostic and therapeutic drugs for optometrists in West Virginia".

In my opinion, most optometrists are hard working, conscientious individuals who do their best to perform the services for which they are adequately trained: testing vision, and prescribing eyeglasses and contact lenses. Most optometrists are careful about referring their patients to ophthalmologists if they detect a visual loss which they cannot correct by glasses, or some other problem with which they are unable to deal effectively. However, some optometrists, not only in our state, but nationwide are attempting to expand the practice of optometry into the primary provider of vision care in the nation. In our state and others, optometrists are now trying to be admitted to hospital staff. This means that they would like to take over all aspects of eye health care including all medical and surgical aspects. They regard ophthalmologists as a small band of obstructionists who are trying to prevent them from winning their political and legal battles. The fact that all of us know that the eye is not only part of the human body, it is one of its most important organs. As a political body, it is your responsibility to protect the public trust and make sure that only those who have the needed training and experience will be entitled to provide this kind of care.

The knowledge and skill required to diagnosis and treat eye conditions is hard won by many years of rigorous training and experience. Ophthalmologists have it, and optometrists don't. Please don't compromise the health care of the citizens of this state by expanding the scope of optometry further.

Sincerely yours,

George W. Weinstein, M.D.

GWW/tkm

Testimony of Deloris W. Bell, M.D.
on Senate Bill 651

Chairman Ehrlich and members of the Senate Public Health and Welfare Committee. Thank you for allowing me to testify in opposition to SB 651. My name is Dee Bell. I am an Ophthalmologist in Overland Park, Kansas. I am President of the Ophthalmology Section of the Kansas Medical Society.

I would like to summarize our remarks:

1. Optometric therapeutic drug legislation has been introduced 39 times; it has passed in 7 states. This legislation is a brand new idea without a proven track record.

2. There are 15 optometry schools in the US; only one state with an optometric school has passed this legislation (Oklahoma).

3. The legislation has been considered in Pennsylvania 4 times and turned down 4 times. I would like to read 3 sentences from their summary from the last time in 1985:

> "The commitee has not been presented with any credible evidence which indicates that the current limitation upon the use of therapeutic drugs of optometrists are in any way impairing the visual health of the people of Pennsylvania." The committee received no evidence of any substantial need for expanded practice, nor did it receive any substantial evidence of increased public benefit which would result from such an expanded scope of practice."

4. Since it was brought up yesterday, let me report on the optometric therapeutic drug experience in West Virginia. There are a number of documented incidences of optometric misadventure and I would like to give you a handout of a few examples.

5. Indeed, physicians of Kansas are ready to discuss any issue on its merits. Ophthalmology sought out and asked Optometry in Dec. 1985 to discuss the issue. We were told we would be sent the bill later. We received the final draft of SB 651 on Saturday, February 22, 1986.

Thank you very much for your time and attention.

Attachment V
2/27/86 S. PH&W

Attachment IV