

Approved \_\_\_\_\_

Date

4-10-87  
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MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Marvin L. Littlejohn at  
Chairperson

1:30 h/h/p.m. on March 30, 1987 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Norman Furse, Revisor  
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Gary Robbins, Executive Director, Kansas Optometric Association  
Peter Brungardt, President Kansas Optometric Association  
Don Synder, Beech Aircraft, Manager of Employee Benefits  
Jerry Slaughter, Kansas Medical Society  
Dr. Art Snow, Practicing Family Medicine/Doctor of Day this date  
Perry N. Schuetz, President of Ophthalmology Association  
Dr. Albert M. Lemoine, Professor of Ophthalmology, K.U. Medical School

Chairman called meeting to order announcing there would be hearings held on SB 113. There will be 30 minutes each allowed for proponents and opponents, with 10 minutes each allowed for questions from committee members. We will adjourn at 3:00 p.m.

Hearings began on SB 113:

Gary Robbins, Kansas Optometric Association gave hand-out, see (Attachment No.1), for details. (Attachment is a packet of several items that he refers to throughout his remarks.) In 1977 the Legislature passed a bill permitting optometrists to use diagnostic drugs to better diagnose conditions of the eye. At that time ophthalmologists and the Kansas Medical society opposed that legislation on several points, i.e., lack of education requirements; projected increase in malpractice premiums; fear of endangerment of public safety for Kansans and perhaps some would be blinded. During the 10 years since, these concerns have been proven to be unfounded. Studies indicate optometrists in practice full time in Kansas are in 74 counties, while ophthalmologists practice in only 24 counties. (see Attachment marked Updating Ks. Optometric Law). By allowing optometrists to use topical drugs patients will save money by eliminating cost of another doctor's visit, plus travel time and time away from work. This legislation will benefit Medicare recipients as well. During the Senate hearings on SB 113, Ks. Medical Society offered 6 amendments, and we have agreed to four in some form. The single most controversial issue, (treatment of glaucoma) was eliminated from the bill. We agreed to be held to the same legal standard of care as those licensed to practice medicine/surgery; we agreed to the limit of scope of foreign body removal; offered a two-week limit on use of antiinflammatory drugs which include steroids. We think this bill represents a reasonable middle ground between the two sides. He concluded with three points, i.e., bordering states have this legislation currently, so we are and will continue to lose Kansans who go across border lines for eye treatment, unless this bill is passed; optometric students ask if Kansas law has been updated to allow use of therapeutic drugs and many have chosen to go out of state for school and practice if this legislation does not become law in Kansas; after reviewing pharmacology training for optometry students, the Pharmacists Association Legislative Committee has decided to remain neutral, and not oppose this particular issue. We support two technical amendments in SB 113, i.e., eliminate the word "use in line 32 on Page 1; the elimination of "diagnostic licensee" in line 358, Page 10. We oppose any further changes in SB 113.

Peter Brungardt, President of Ks. Optometric Association and a practicing Optometrist gave hand-out, see (Attachment No.2), (Attachment includes several items that he referred to throughout his remarks. Optometric education is a four year post graduate curriculum based on basic biological sciences/studies of physical/optical properties of light. He referred to handout detailing pharmacology instruction from University of Indiana;

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at \_\_\_\_\_ a.m./p.m. on March 30, 1987

Hearings continue on SB 113--

Pharmacology Training in schools, A comparative Analysis; letter from Dr. Walls, an optometrist/physician; changes in optometry at University of Houston. He detailed educational requirements; changes in the practice of optometry. He stressed there is a continuing education program available to optometrists through journals, books, seminars, and continuing education courses. In cases of foreign body removal, optometry is very well versed in various levels of corneal anatomy. We understand complications and characteristics involved and have the equipment and knowledge needed to manage, treat, or refer corneal foreign material. An exact diagnosis of red eye difficulties isn't attempted often because the primary physician does not have the biomicroscope necessary to differentiate difficulties. I don't wish to criticize care described by primary care medicine, but only to acquaint you with current standard of care. SB 113 will raise level of treatment in safety and efficacy provided by an optometrist. Optometrists should manage most of patients problems most of the time. We wish to employ medications on the eye surface and to treat conditions limited to the eye. Ophthalmology is and will continue to be the provider of specialty care of eye care. He then discussed eye treatment with steroids, i.e., some conditions made worse with steroids. The optometrist is well aware of benefits and drawbacks of all medications for use in primary care, and patients should not be denied the comfort steroids can provide when needed. They should not require secondary referral for common problems. He then discussed approaches and tactics used by medicine in other states. He concluded by saying optometric practice is overwhelmingly approved by Kansas citizens. He urged for favorable passage of SB 113.

Questions were answered; if this legislation is passed, yes, we would probably ask for further updating of the practice of optometrics in about 5 years from now; composition of Optometry Board is three optometrists and one consumer. There was discussion in regard to insurance coverage for eye care being a small percentage of insurance coverage.

Don Snyder, Manager of employee benefits of Beech Aircraft Company stated if SB 113 is passed, insurance costs will increase. Whenever you add a provider group, insurance costs increase. Both large and small companies will be affected by this if optometrists are given right to submit bills to Insurance Companies for eye care services rendered. There will be vast increases. He detailed personal experiences about eye problems in 1982. After problems with an optometrist, he then went to an ophthalmologist and today his eye condition is nearly well. He asked members not to listen to special lobby groups who have a vested interest in this legislation, but to consider the well being of the Kansans who seek eye care.

Jerry Slaughter, Kansas Medical Society gave hand-out, (see Attachment No.3) for details. Our organization does not view SB 113 as a compromise bill, we think it will set a bad precedent, and we are in opposition to it. We feel legislation should enforce a strict high standard ways of prescribing drugs, especially in regard to eye care. Optometrists are asking you in SB 113 to grant them authority to practice medicine and to treat people with serious eye diseases. Nothing in the bill requires an optometrist to seek medical consultation for patients with serious eye disease. If this legislation is passed, you are saying that someone with less training than a physician is fully capable of treating eye disease. If that should be allowed, why require physicians to go through a rigorous 7/8 years of medical school and clinical residency training? We feel this legislation would be a step backwards. We've been down this road before. Where will the demands of this group end? If this is granted, how can you refuse their desire to continue to expand their practices in the future? At what point will you say no to those who want privileges broadened? If optometrists wanted to practice medicine, why don't they seek a medical education? They are asking for shortcuts here in this bill. Your action on SB 113 will send a message to every group in Kansas that to practice medicine in Kansas requires only a couple of weekend courses. We urge you to report SB 113 adversely.

## CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFAREroom 423-S, Statehouse, at 1:30 a.m./p.m. on March 30, 1987

Hearings continue on SB 113--

Dr. Art Snow, President of Ks. Academy of Physicians, gave hand-out, (see Attachment No.4), for details. Optometrists are asking to perform diagnosis and prescribe medications to treat eye disease. Rather than attend medical school to attain this right, they are asking the legislature to give them this privilege. The real issue here is that we must all be concerned about the quality of eye care for people of Kansas. We in family practice are adequately trained in all areas of medicine, including the care of eye problems. He expanded on the educational requirements to become a medical doctor/ or ophthalmologist. He expanded on diseases of the eye, and medications for treatment of same. Some medications placed in the eye can and do provide relief but also can and do lead to potentially dangerous side effects. Complete medical training is necessary to adequately diagnosis and prescribe for treatment of eye diseases. A thorough medical background is necessary to deal with complications that may arise. We feel, he said Kansans deserve nothing less than the best in eye care, (or any other medical care). Let's leave medical treatment to physicians he asked. He asked members to consider defeat of SB 113.

Perry N. Schuetz, President of Ophthalmology gave hand-out, (see Attachment No.5), for details. He spoke in opposition to SB 113. Said he feels this legislative body is being asked to fix something that isn't broken, or perhaps break something that is already fixed. He had hoped there would be more time to discuss this important issue. This bill if passed could result in danger for eyes of Kansas; welfare of people would be jeopardized. The suggestion to amend the bill in removal of glaucoma therapy only mitigates some of these inherent dangers. Their society opposes the methodology of offering a five weekend course to paramedical personnel, to certify them to treat the public. To offer this would be the same as to offer same courses to opticians or physicians assistants and teach them the scope of traditional optometry. Would this legislature stand ready to certify these groups to an expanded scope of practice which would include optometry? He doubts it. Their society opposes the hypocrisy of telling the public that equal standard of care is rendered by these vastly different professions, the optometrist and the ophthalmologist. Where would you go if you were faced with a blinding disease? We do not support any compromise relating to this legislation. Amendments offered to SB 113 have been offered by concerned legislators wishing to protect the public. Legislation expanding optometry into thereapy is merely the first step in a legislative journey; all topical medications, oral medications, narcotics, minor office surgery, laser surgery; all other surgery will be the next requests for expansion of practice. If SB 113 passes, it should be required the bill be hung on each optometrist's wall in lieu of the appropriate diplomas which are missing.

Dr. Albert M. Lemoine, Professor of Pphthalmology, KU Medical School spoke to SB 113. In 1977 he came before the legislature in support the use of drugs for diagnostic purposes by optometrists, and still support that position, but I am opposed to therapy. Medicine is not an exact science, and as a result each person presents separate problems, therefore the educational requirements for optometrists is not extensive enough to confront all the medical problems that may arise. He outlined the education criteria required for both group, indicating graphs and charts, (see Attachment No. 6), for details.) Optometric students are taught basic keys in diagnosing serious problems, then referrals to the Ophthalmology M.D.'s are an important part of the next step, patient treatment. He stated he cannot support SB 113. The lack of patients with serious eye disease the optometrists treat during their training just does not give them the necessary experience and exposure. At this time the formal education of the optometrist is not adequate. This is no reflection on the intelligence of those students, but competence is only accomplished through a thorough education. He answered questions, i.e., yes, there are many people going across the states borders for eye care; X number of training hours does not necessarily solve all the problems; 90 % glocoma patients could be treated in a certain way, and 10% another, but there are some in each group that could have problems if proper treatment not given.

Questions asked in regard to insurance concerns; proper referral when special eye problems occur; many drugs cause side effects and proper education is vital in such cases.

Printed testimony from Richard Griffiths, V.Pres. Industrial Relations of Beechcraft Company, (see Attachment No.7), for details, and from Ron Gaches, Boeing Military Airplane Company, (see Attachment No.8), for details.

Meeting adjourned. Next meeting, if any will be on call of Chairman.

Page 3 of 3

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 3-30-87

NAME	ORGANIZATION	ADDRESS
Perry N. Schuef MD	Ks state Ophthalmological Soc.	Great Bend
Albert N. Lemon J	"	Leawood KS KUAC
JERRY STALLER	KMS	Topeka KS
Donald E. Beahm MD	Ks councillor to American Academy of Oph.	3923 Broadway St Bend, Ks.
Dee Bell	Kms.	Overland Park, Ks
Walt Bode	Ks. Academy of Family Physicians	Wichita
ART SNOW M.D.	Doctor of the Day	Shawnee Mission
Frank Griffith MD	Ks state Ophthalm Society	Salina KS
Rebecca Crenshaw	Ks State Ophthal. Soc.	Topeka
Leslie H. Greenwood	Rep. Hawke (dentist)	Topeka
CHARLES G. PEIER	KBEA	"
John A. Sumner	KOA	"
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
BILL HORN	BANKERS LIFE NEBRASKA	WICHITA
ROBERT ERLANGER	BANKERS LIFE NEBRASKA	WICHITA
Rory G. Harris	Ks Optometric Assn	TOPEKA
Jim Yavally	Kansas Optometric Assoc.	Topeka
GREG BESLER, O.D.	K.O.A.	OVERLAND PARK
HAROLD PITTS		Topeka
RON CACHES	BMAC	WICHITA

# Kansas Optometric Association

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## TESTIMONY

### HOUSE PUBLIC HEALTH & WELFARE COMMITTEE

MARCH 30, 1987

Thank you, Mr. Chairman, I appreciate the opportunity to appear in support of Senate Bill 113. I am Gary Robbins, Executive Director of the Kansas Optometric Association. Our association strongly urges the passage of this legislation. In 1977, the Kansas Legislature passed a bill that permitted optometrists to use diagnostic drugs to better diagnose conditions of the eye. This legislation also held optometrists legally accountable for any failure to diagnose a condition of the eye including glaucoma, cataracts and a multitude of other conditions affecting the eyes. At that time ophthalmologists and the Kansas Medical Society opposed that legislation on three basic grounds. The first was a lack of education, the second was a projected dramatic increase in malpractice premiums for optometrists and finally a fear for the endangerment of public safety would be endangered and Kansans would be blinded.

During the past ten years, these concerns have proved to be unfounded; and the citizens of Kansas have been beneficiaries of excellent vision care from optometrists. During the last decade the State Board of Examiners in Optometry has not received a single complaint involving the misuse of a diagnostic drug. I would submit to you that the scenario facing you today is identical. In 1977, the legislature heard the same objections, but still enacted

drug legislation. We don't believe that requesting an update in our practice act every ten years is unrealistic. It is needed to reflect changes in optometric education and training.

1-A  
We believe there are several basic facts that need to be examined. The first is the current distribution of optometrists and ophthalmologists. If you turn to the center of the white booklet in my handout materials, you will see that optometrists practice full time in 74 counties while ophthalmologists practice in only 24 counties. In fact, over 70% of the ophthalmologists in Kansas are located in only 7 counties. By allowing optometrists to use topical drugs, it will save patients money by eliminating the cost of another doctor's visit plus the resulting lost travel time and the time away from work.

West Virginia was the first state to pass this type of legislation in 1976. I have reproduced a copy of the report from the West Virginia Optometric Association to their state legislature. During the first five years after this law was passed, West Virginia citizens were saved almost two million miles in driving alone because optometrists were permitted to use therapeutic drugs. The report also notes that there were no adverse drug reactions reported to the West Virginia Board of Optometry nor any malpractice suits filed.

Last session, a West Virginia optometrist testified before the Senate Public Health and Welfare Committee that his malpractice insurance was \$323 per year after practicing with a drug law for ten years. Today, you will probably be told that State Farm Insurance will not write liability insurance for optometrists in

states with a drug law. This is a true statement. However, State Farm writes malpractice insurance only on a limited basis, primarily for optometrists and veterinarians. St. Paul Insurance expects higher liability insurance exposure for optometrists with therapeutics, but they also project more contact lens liability suits from extended wear contact lenses. We expect this law will help minimize complications from contact lens wear or other minor conditions which could actually have a positive affect of reducing our liability exposure. We believe that the \$323 premium by the West Virginia optometrist after ten years reflects this assumption. There are over ten companies writing malpractice insurance for Kansas optometrists and no problem exists with availability.

1-B  
Recently a study was released by the University of Richmond School of Business which noted that the passage of a therapeutic drug law in Virginia would result in a minimum of 2.8 million dollar annual savings. It is virtually impossible to state what savings will occur from the passage of this legislation in Kansas. However, it is obvious that it will eliminate a second doctor's visit for routine conditions plus travel expenses and lost work time.

Last fall, one additional development occurred which we had not anticipated when we started working on this issue. Congress passed legislation that, as of April 1, 1987, will reimburse optometrists under Medicare in every state for the treatment of eye diseases if the state law permits it. The Health Care Financing Administration and Congress believe this will result in a cost savings and still provide quality care by allowing optometrists to

practice at their highest level of competence. This legislation will benefit Medicare recipients in Kansas as well. The federal government has experienced positive results by allowing the use of drugs by optometrists in the VA system, Armed Services and the Indian Health Service. In addition, studies in HMO's have also pointed out the savings which have occurred by using optometrists to the full extent of their training. Optometrists are independent practitioners who are already reimbursed in most major health insurance programs offering a vision plan. It is our understanding after visiting with representatives of several major health insurance companies that the passage of this bill will not increase or decrease the cost of health insurance. There will be some savings when companies have been paying for two visits, but the impact in the overall picture of health insurance will be minimal.

I would like to give you a brief history of this bill. We introduced legislation last session and the Senate Public Health and Welfare Committee held hearings. The ophthalmologists indicated that if the committee delayed voting on the issue for a year, that a compromise could be reached with the optometrists. Both sides agreed to this process. Then Senator Jack Walker agreed to convene the meetings. We offered a proposal including several compromises on our part during the negotiation process. The ophthalmologists countered with a proposal which eliminated the diagnostic drugs which we have been using for ten years, and offered the use of Visine which is available over-the-counter. They indicated that this was their bottom line and no compromise was possible.



During the Senate Public Health and Welfare Committee hearings this session, the most controversial provisions were deleted by that Committee, and we agreed to other major "suggestions" by the Medical Society. The Kansas Medical Society offered six amendments to this bill just prior to action by the Senate Committee. We in fact, agreed to four of those amendments in some form. The single most controversial issue -- the treatment of glaucoma -- was eliminated from the bill. We also agreed to be held to the same legal standard of care as someone licensed to practice medicine and surgery. We further agreed in amendments to limit the scope of foreign body removal and offered a two-week limit on the use of anti-inflammatory drugs which includes steroids. My point is, that the ophthalmologists indicated before the Senate Committee that compromise was not possible, but we attempted to address their concerns. This bill represents a reasonable middle ground between the two sides.

A final area of debate before the Senate Committee was the ploy of sending this issue to credentialing. The committee recognized that optometrists have been credentialed in this state under a licensure law for over 50 years. In addition, Secretary of Health and Environment, Dr. Jack Walker, ruled this was not an issue for credentialing.

I think it is important to realize that the bill you have before you is more conservative than legislation passed in some of our neighboring states. For example, Oklahoma allows the treatment of all forms of glaucoma with the use of topical anti-glaucoma drugs. The Missouri legislation prohibits glaucoma but allows the

use of oral drugs which is not included in our legislation. Neither state has a time limit on the use of steroids. In addition, this bill requires 100 hours of education and testing before an optometrist would be allowed to use topical therapeutic drugs. The number of hours of continuing education is doubled and the State Board of Examiners in Optometry is given the flexibility to increase it if they deem appropriate. The bill has a strong surgery prohibition and does not permit grandfathering of anyone, regardless of academic preparation.

In conclusion, I would like to make three final points. The first is that fourteen states have this legislation. I have a map for your reference which doesn't reflect the passage of bills in Arkansas and Wyoming. We are seeing patients in border Kansas counties leave our state to obtain these services in adjacent states. If we do not pass this legislation this session, this problem will only get worse.

The second is that we have Kansas students in optometry schools in Texas, Missouri, Indiana and Oklahoma. We are working hard to encourage them to come back to Kansas. When I meet with them to encourage them to locate here, the first question that I hear is, "Have you updated Kansas' law to allow for the use of therapeutic drugs so we can practice what we have learned in optometry school and practice at our highest level of competence?" As more states pass this type of legislation, we are going to be at more of a disadvantage in recruiting optometrists to Kansas.

There is one final point which I want to mention. We met with the Kansas Pharmacists Association Legislative Committee to


discuss this issue. They had a number of questions, and we expected them to oppose along with the other organizations you will hear in a few minutes. However, after they reviewed the pharmacology training available in the schools of optometry plus the additional training taken last fall, they decided to remain neutral. I would suggest that this is the most independent evaluation available to you on this issue.

I know legislators sometimes feel they lack the proper qualifications to determine what's "right" on an issue of this type. But, the question of updating the practice of optometry isn't going to go away. Students in schools of optometry have been trained to do the things permitted by this bill. It is unreasonable to expect someone to know how to better serve their patients and not seek legislation to make it possible, especially when it greatly enhances the delivery of health care and reduces costs.


*Amendments* We support two technical amendments to Senate Bill 113. The first is elimination of the word "use" in line 32 on page 1 and the second is the elimination of the word "diagnostic licensee" in line 358 on page 10. We oppose any further changes in Senate Bill 113 because it represents a fair middle ground to both sides.

In the interest of time, we will present only one additional witness; and hopefully when Dr. Brungardt finishes, we will be glad to answer any questions that the committee may have. I want to introduce the President of the Kansas Optometric Association, Dr. Pete Brungardt from Salina which served as the Western end of I-70 in Kansas this weekend.

# Updating Kansas Optometry Law



## **KANSAS OPTOMETRIC ASSOCIATION**



# Purpose

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## **Objectives of the bill**

The Kansas Optometric Association is supporting legislation to update the Kansas Optometry Law. This legislation will permit doctors of optometry to utilize their education to prescribe and use topical pharmaceutical agents for the treatment and management of eye diseases. This legislation will ensure the availability of quality vision care at a reasonable cost to the residents of Kansas. This document contains a summary of the legislation being requested as well as documentation supporting our belief that this legislation is in the public interest.

We expect opposition to this legislation from organized medicine in general and ophthalmologists in particular. Although medicine's questions appear to be about the optometric education and the public safety, the real reasons for their opposition are economic. It is optometry's belief that the legislation speaks to and provides safeguards to the public.

If you would like additional information or documentation, we would be happy to provide it.

## Why should the scope of Optometric Practice be updated?

1. This change is a tried and proven method of lowering the cost of eye care for the consumer without lowering the quality of care.
2. Health care practitioners, including optometrists, are responsible for providing their patients with the highest level of eye care consistent with their education and training.
3. Current optometric training provides the doctor of optometry with the skills and expertise necessary to update his or her scope of practice to include the use of medications to treat common eye disease.
4. Changes in Kansas statutes have lagged behind the advances and expansions of optometric education and training, thereby preventing Kansas optometrists from providing the best possible care to their patients.
5. It has been conclusively demonstrated in other states that the use of pharmaceutical drugs by qualified optometrists to treat common eye diseases is safe and cost-effective.
6. At present, optometrists are legally required to diagnose eye disease. Treatment of the disease that has been diagnosed is a logical extension of this requirement.
7. In many Kansas communities, the doctor of optometry is the only health professional who is specifically trained and licensed to detect and diagnose eye disease and monitor a program of treatment.
8. HMO studies have shown that the utilization of doctors of optometry to the full extent of their training lowered the cost of care by as much as 36%.
9. The far greater accessibility of the doctor of optometry, who serves as the primary provider of eye care services, greatly increases the cost-effectiveness of eye care.
10. Optometrists currently maintain specialized equipment that allows proper diagnosis, treatment and monitoring of eye disease conditions. This includes tonometers, automated visual field instruments, biomicroscopes, ophthalmoscopes, binocular indirect ophthalmoscopes and fundus cameras.

# Overview

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## Five reasons for updating Kansas Optometry Law.

- Kansas optometrists are educationally prepared to diagnose and treat their patients.
- Kansas optometrists are more accessible and better equipped to provide efficient care.
- Allowing optometrists to treat the conditions they now diagnose will save Kansas citizens money.
- Kansas optometrists' track record proves their effectiveness in diagnosis and treatment.
- Kansas optometrists should be allowed to provide the public the full benefit of their training and experience as vision care professionals.

### 1. Education

The average optometry graduate has eight years of college and graduate education, the first four being in predominantly pre-medical school courses.

Optometry students receive more hours of training in the diagnosis and treatment of eye disease than do general medical students.

Optometrists' education in pharmacology is comparable to that of medical students in terms of hours with emphasis on ocular pharmacology in optometry school.

### 2. Efficiency

Optometrists practice full-time in 74 of 105 Kansas counties while ophthalmologists practice full time in only 24.

By virtue of their training and the availability of specialized instruments, optometrists are better equipped than general physicians to diagnose and treat eye disease.

### 3. Economics

Optometrists' fees are generally lower than those of physicians and hospitals. Increased competition in the service of primary eye care will help control those costs.

The cost of a visit to another doctor or hospital will be eliminated.

Extra travel time will be eliminated.

Extra time away from work will be eliminated.

This bill will allow optometrists to treat the same conditions that they have been diagnosing.

### 4. Effectiveness

Since 1977, optometrists have been permitted to use drugs for diagnostic purposes. There have been no reports of significant adverse reactions.

Although there has been an increase in all liability insurance premiums, malpractice premiums for Kansas optometrists showed no significant increase following legislation authorizing them to use drugs for diagnostic purposes. In the twelve states where optometrists are currently permitted to treat eye disease, there has been no significant increase in malpractice premiums due to the legislation.

### 5. Equity

All professions must constantly improve their knowledge and skills. Optometrists are currently updating their skills in the treatment of eye diseases through continuing education and clinical programs.

At the present time, two non-physician health professions (doctors of dentistry and doctors of podiatry) are permitted by Kansas law to administer and prescribe drugs for the treatment of disease. Doctors of Optometry have similar education, without similar privileges.

Optometrists have proven themselves to be competent, conscientious health professionals.

## **Kansas Optometrists are educationally prepared to diagnose and treat their patients.**

Optometric education has expanded beyond the framework of current state law. Like any profession, optometry would like to be allowed to provide those expanded services which are consistent with the current scope and training of its member doctors of optometry.

1. The average educational background of an optometrist is eight years of college-level and advanced graduate study. 92% of all optometric students are in their fourth year of undergraduate study when entering optometry school. This undergraduate study includes general biology and microbiology, general and organic chemistry, physics, calculus and psychology. The optometry curriculum is a four-year program which includes studies in optics, pharmacology, disease processes, detection and treatment of eye disease, microbiology, neurology, physics, physiology, anatomy, and public health.
2. Clinical training and experience is received in veterans administration and general hospitals as well as outreach clinics in a variety of urban and rural settings. These programs are under the direct guidance and supervision of optometrists and medical doctors, including board certified ophthalmologists.
3. Among the health professions trained in therapeutic pharmacology (medicine, dentistry, podiatry, and optometry), only optometry is restricted to the use of certain diagnostic pharmaceuticals. Optometric training in pharmacological aspects of systemic conditions is at least equal to that of dentistry and podiatry.
4. All schools and colleges of optometry are accredited by the same organizations which accredit medical schools.
5. Kansas optometrists, after graduating from an accredited school or college of optometry, must further demonstrate competency by successfully passing a state board examination prior to being licensed to practice.



# Education

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6. Since 1940, Kansas law has required that optometrists complete 10 hours per year of continuing education in order to renew their licenses to practice. This bill would double the current requirement to twenty (20) hours per year.
7. The proposed amendments to the statute will not allow "grandfathering" of presently licensed optometrists to use therapeutic pharmaceutical agents. Each optometrist will be required to provide evidence of having received the required 100 hours of transcript-quality training, and demonstrate competence in order to be certified to use therapeutic pharmaceutical agents.
8. *The Gourman Report*, a rating of graduate and professional programs in American universities, gave each of the 13 schools and colleges of optometry its highest rating, with scores ranging from 4.67 to 4.96 on a scale of 5.0. Only 15% of American medical schools received the highest rating, and only 13% scored as high as the optometry schools.
9. Optometric education includes more than 1500 hours of training specifically related to the diagnosis and treatment of eye disease. In addition, optometric students see between 1000 and 2000 patients in over 1200 hours of clinical experience.

Joseph C. Toland, M.D.  
Professor of Ophthalmology  
Jefferson Medical College  
Philadelphia, PA

*"Optometrists are more capable of diagnosing eye disease than general practitioners . . . Optometrists are more than adequately educated in the basics of pharmacology and the rational use of drugs as professionals."*

10. In other states currently using therapeutic pharmaceutical agents, optometrists and physicians (including numerous ophthalmologists) indicate optometric use of TPA's has resulted in earlier quality treatment of ocular conditions, better working relationships between medicine and optometry, and substantial cost savings to the public.

11. Optometry students receive an average of 156 hours of classroom training in pharmacology (the use and interaction of drugs), about one-half of which is specifically related to drugs used in the diagnosis and treatment of eye disease. Medical students typically receive a comparable number of hours in pharmacology; however, only a small part of that pharmacology is related to the eye.

In recent years the expansion of medical knowledge has led to a decrease in the amount of training physicians receive in the diagnosis and treatment of eye disease. A survey by the Association of University Professors of Ophthalmology showed that the average medical student in the United States receives only 22 hours of lectures and demonstrations on eye conditions during the entire four years of medical school. The editor of the *American Journal of Ophthalmology* has stated, "One can no longer depend upon primary care physicians to have a general awareness of ocular abnormalities." It is our position that optometry can provide this care for our patients.

Robert E. Kalina, M.D., in  
*American Journal of Ophthalmology*  
March, 1982

*"There is much less ophthalmic instruction in medical schools today than in those of a generation ago. One can no longer depend upon primary care physicians to have a general awareness of ocular abnormalities."*

Henry J. L. Van Dyk, M.D., and  
George W. Weinstein, M.D., in  
"Ophthalmology Training in  
Medical Schools"  
*Journal of Medical Education*  
February, 1981

*"There was a decline in mean required curriculum hours from 25 in 1974 to 22 in 1979, while the median declined from 18 to 15. Hours actually assigned to the department or division of ophthalmology decreased proportionately from a mean of 22 in 1974 to 20 in 1979. Assigned hours were most frequently for lectures or demonstrations . . . (Instances in which ophthalmology teaching is done in a primary care clinical setting) . . . are rare, often unscheduled, and likely to be the first to suffer from time constraints."*

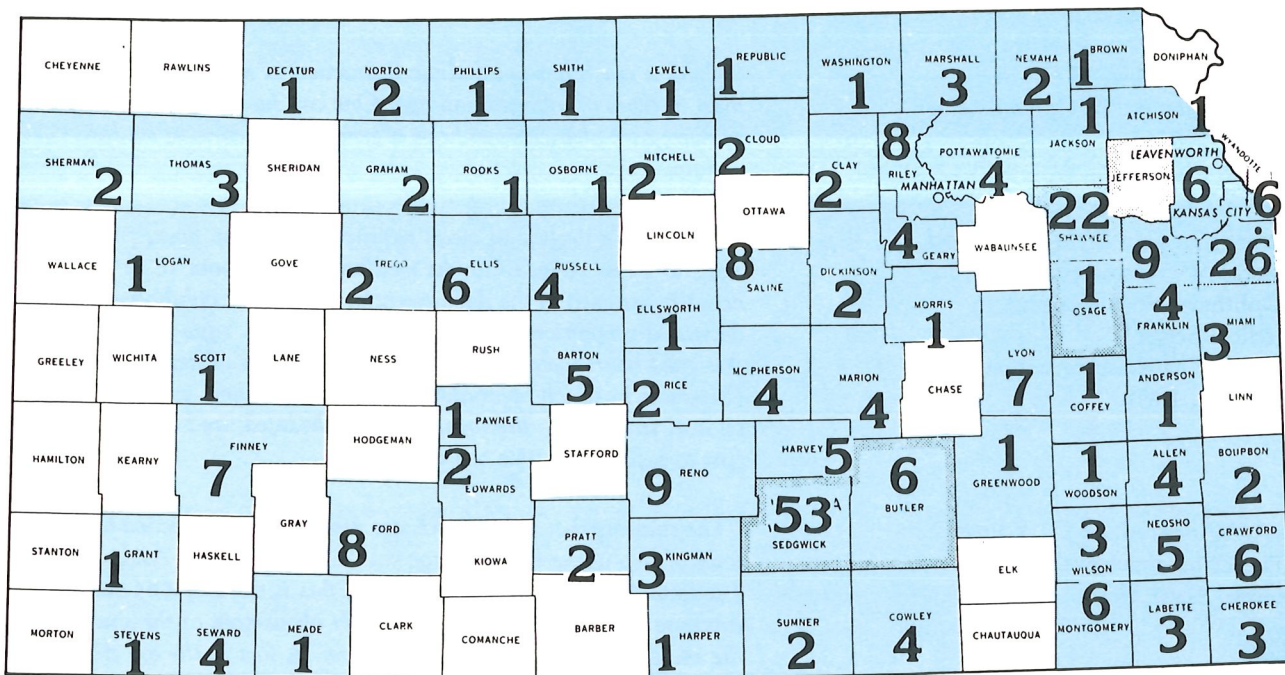
L. A. Winograd, M.D., Editor  
"The Ophthalmologist"  
March/April 1978

*"The students that I now teach are assigned on an elective basis for a total of two weeks in the Junior year to the eye clinic! Aside from a few lectures in the basic science years, this is the extent of their exposure to ophthalmology — and only about 50% of the students elect the eye clinic. The other 50% may never set foot in the eye clinic before graduation!"*

# Efficiency

**Kansas  
Optometrists are  
more accessible  
and better  
equipped to  
provide efficient  
eye care.**

Optometrists practice full time in 74 of 105 Kansas counties while full time ophthalmologists practice in only 24, primarily in the large urban areas.



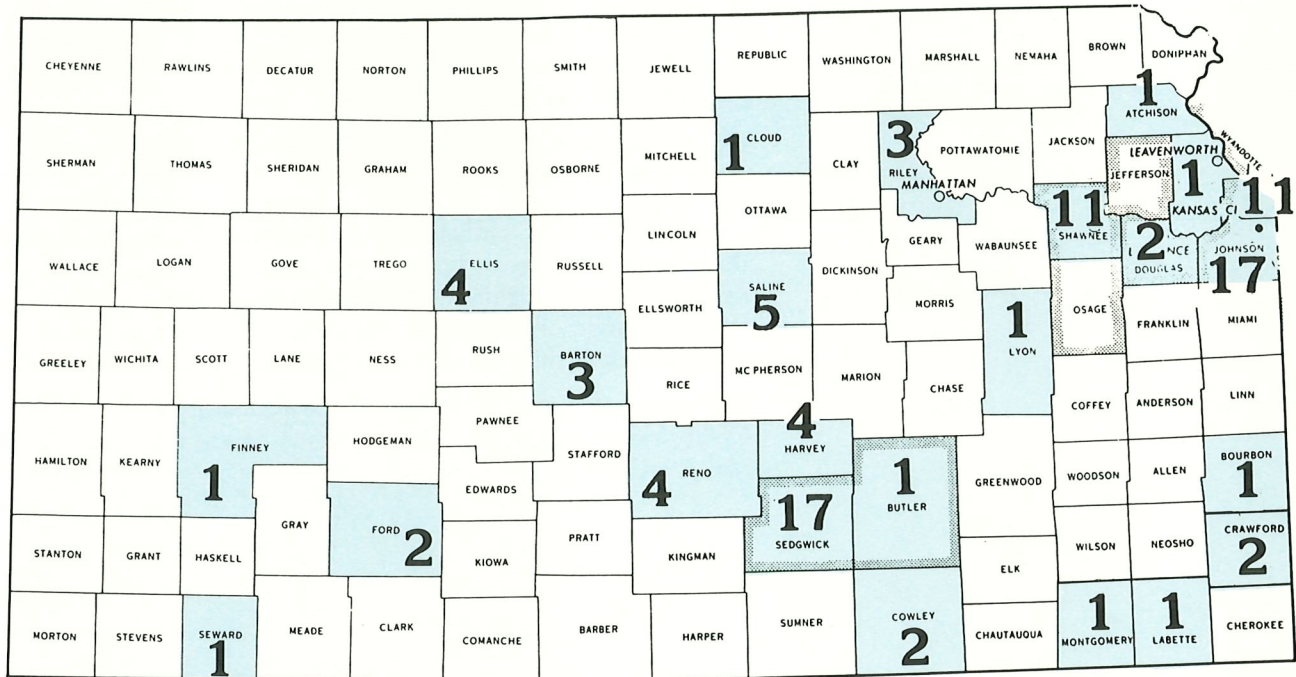
Distribution of  
Optometrists  
January, 1987

Total 318 Optometrists

# Efficiency

By virtue of their extensive training and the availability of specialized instruments, optometrists are better equipped than most non-specialized physicians to diagnose and treat eye disease.

71% of the ophthalmologists are located in only seven counties.



Distribution of  
Ophthalmologists  
January, 1987

Total: 97 Ophthalmologists

# Economics

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## **Allowing Optometrists to treat with drugs will save Kansas citizens money.**

Douglas J. Colton, J.D.  
Anti-trust Attorney  
Washington, D.C.

1. Optometrists' fees are generally lower than those of physicians and hospitals. It is cost-effective to allow optometrists to practice at their highest level of competence.

Numerous HMO's have concluded that it is financially more practical for all patients to be seen by optometrists before being referred to ophthalmologists for secondary or tertiary care.

2. Allowing optometrists to treat the conditions they now diagnose will save the public money by eliminating the cost of a visit to another doctor or hospital and eliminating extra travel time and time away from work.
3. This bill will eliminate the medical monopoly on the treatment of eye disease.

*"With both their incomes and egos in jeopardy, it's not surprising at all that ophthalmologists, or any other similarly situated group, would react the way they are. What we're seeing is economic guerrilla warfare . . . It's a straight pocketbook issue. Ophthalmology's attempts to limit optometry's scope of practice are, not surprisingly, cloaked in the garb of public health and welfare. But they're nothing of the sort. Ophthalmology is trying to protect its source of revenue."*

**Ophthalmologists have told the courts in at least three states that this is an economic issue.**

- The Rhode Island Ophthalmological Society brought suit claiming that the use of drugs by optometrists encroached on ophthalmologists' rights and privileges and that the implementation of legislation permitting them to do so would seriously retard the advancement of ophthalmology in the state.

*The suit was dismissed by the Superior Court: Rhode Island Ophthalmological Society v. Cannon, 317 A.2d 124 (R.S. Sup. Ct., March 27, 1974).*

# Economics

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- A group of West Virginia ophthalmologists, in conjunction with the West Virginia State Medical Association and the West Virginia Academy of Ophthalmology and Otolaryngology, brought suit claiming that legislation that would permit the use of drugs by optometrists had “. . . usurped the powers and privileges of plaintiff doctors . . . who will suffer from economic and monetary standpoints.”

*The suit was dismissed: Civil Action No. 76-1214 (6th Circuit Court of West Virginia, December 13, 1967.)*

- The Florida Medical Association, The Florida Society of Ophthalmology, and a group of ophthalmologists brought suit claiming, “All Florida physicians and ophthalmologists have professional and economic interests which are, or will be, affected . . . (by the use of drugs by optometrists).” The suit went on to claim that this would allow optometrists “. . . to provide medical eye care through the use of and prescription of non-controlled drugs in direct competition with, and to the economic detriment of, said members.”

*The suit was dismissed: Case No. 82-1886R (Florida Division of Administrative Hearings, August 31, 1982).*

In each of these cases the plaintiff ophthalmologists also claimed that the public health (in addition to their own economic health) would be jeopardized by the use of drugs by optometrists. In each case the court rejected this argument, also. Ophthalmology’s claim that the public health would be jeopardized, has never been substantiated.

# Effectiveness

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## **Kansas Optometrists' track record proves their effectiveness in diagnosis and treatment.**

1. Since 1977 Kansas optometrists have been permitted to use drugs for diagnostic purposes. There has never been a report of a significant adverse reaction.
2. Except for the general increase in all liability insurance costs, malpractice premiums for optometrists have not increased significantly in the last five years.
3. In West Virginia, where optometrists have been using therapeutic drugs for ten years, malpractice claims against optometrists have been minimal or non-existent. In the same ten years, however, 47% of all West Virginia physicians had at least one malpractice claim filed against them. In testimony before the Kansas Senate Public Health and Welfare Committee last year, a West Virginia optometrist testified that his malpractice rates were \$323 which is less than the amount most Kansas optometrists are currently paying who cannot provide this care. Malpractice insurance rates are much lower for optometrists in West Virginia than for medical doctors. This is also true for North Carolina, where optometrists have been prescribing medications since 1977.

It is important to know that learned professions do not stand still. All professions have advanced in acquired knowledge, skills, and experience. Optometry is no exception.

1. Intraocular implants, laser surgery and refractive surgery are examples of procedures not even developed 15-20 years ago. Medical practitioners have learned these procedures and developed skills through post-graduate education and training. Schools of medicine have now implemented these procedures in their routine training.
2. Optometric education has likewise advanced tremendously in teaching and training students in the proper diagnosis, treatment and management of ocular diseases and their systemic manifestations. The number of hours of lecture, clinical training, and experience, and the total number of patients seen by optometric students has increased dramatically within the last 15-20 years. Students at numerous optometry schools take the same classes as do medical and dental students. Classes relating to ocular disease, its treatment and management, pharmacology, and systemic conditions are taught by professors with M.D. and Ph.D. degrees.
3. Currently 48 states allow optometrists to use diagnostic agents and 12 states allow use of therapeutic agents.
4. Kansas optometrists have been using diagnostic drugs since 1977 with no significant adverse reactions. Some of these same diagnostic agents are actually also used for therapeutic purposes.
5. Kansas optometrists have been diagnosing ocular diseases as well as recognizing systemic abnormalities for years. Systemic conditions recognized by optometrists during a primary vision care examination include diabetes, hypertension, kidney disorders and many other similar conditions. These patients have not only been referred to ophthalmologists but also to neurologists, internists, family practitioners, and other specialists for appropriate care.

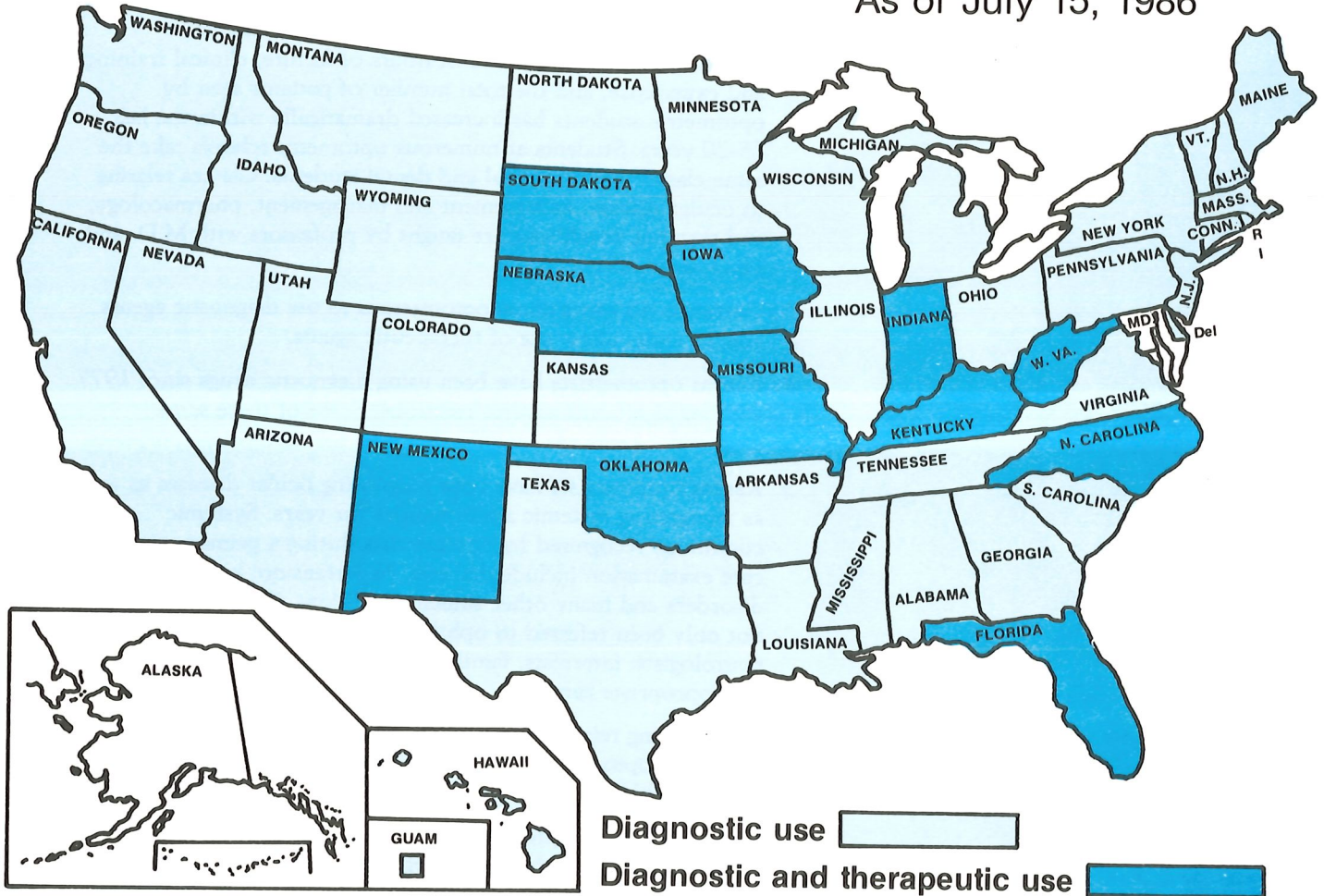
The working relationship with these physicians has given the practicing optometrists vast experience in the management of health problems.

6. Over 190 Kansas optometrists have now completed a six credit hour graduate level therapeutic pharmaceutical and treatment course given by the Pennsylvania College of Optometry. This 100 hour lecture and clinical laboratory course is the same course given in other states that currently allow optometrists the use of therapeutic agents. The instructors included not only optometric educators, but also Ph.D.s in pharmacology, general practice physicians, and board certified ophthalmologists. In addition, Kansas optometrists will be further trained in the clinical aspects of eye disease treatment by numerous Kansas ophthalmologists. These cooperating ophthalmologists are committed to excellence of care for all Kansas citizens and realize that primary eye care carried out by the trained optometrist is the best way to achieve this goal.



# State pharmaceutical legislation

As of July 15, 1986




*If you have any questions,  
please contact your  
optometrist or the  
Kansas Optometric Association  
400 Kansas Avenue, Suite A  
Topeka, Kansas 66603  
913-232-0225*

**THE PECUNIARY SAVINGS ASSOCIATED WITH OPTOMETRIC USE  
OF  
THERAPEUTIC PHARMACEUTICAL AGENTS**

**A PRELIMINARY REPORT  
PREPARED FOR  
THE VIRGINIA OPTOMETRIC ASSOCIATION**

Prepared  
by  
Thomas J. Cosse, Ph.D.  
Robert W. Cook, Ph.D.



**SUMMARY OF FINDINGS**

* NUMBER OF QUESTIONNAIRES DISTRIBUTED - SURVEY POPULATION	518
* ADJUSTED SURVEY POPULATION	479
* NUMBER OF USABLE RESPONSES	280
* RESPONSE RATE	58.5%
* TOTAL NUMBER OF PATIENTS DIAGNOSED BY RESPONDING OPTOMETRISTS	15,479
* ESTIMATED TOTAL SAVINGS IF OPTOMETRISTS TREATED CONDITIONS	\$2,851,472

## PROFESSIONAL OPINION OF PRINCIPAL INVESTIGATORS

Using sound research techniques, we estimate the minimum annual savings to Virginians would be \$2,857,472 if optometrists are authorized to use ocular therapeutic pharmaceutical agents in the treatment of selected eye conditions.

This is regarded as a conservative estimate due to the level of response to this survey by optometrists. Specifically, this estimate is based on the number of persons diagnosed by responding optometrists and the fees they indicated would be charged for diagnosis and treatment. We believe that the optometrists who chose not to respond to the survey may also have diagnosed patients with the subject conditions during the time frame encompassed by this study. As only 280 of the approximately 500 optometrists responded to the survey, it is likely that the number of patients diagnosed with each condition is larger than the number of patients used in our calculations. Thus, assuming that the fees charged by nonresponding optometrists are similar to the fees charged by responding optometrists, the savings will also be larger than those reported above.

The findings of this research study, like those of any research study, should be used with caution. The estimates are based on self-reports by optometrists who chose to participate in the study. The investigators did not have access to the patient records of the responding optometrists and were not able to verify the accuracy of the responses. Further, this report does not include an evaluation of the medical issues associated with the treatment of eye conditions by optometrists.

## Purpose

This study was conducted to determine the financial implications to Virginians if optometrists are authorized to use ocular therapeutic pharmaceutical agents in the treatment of selected eye conditions. Funding for the study was provided by a grant from the Virginia Optometric Association.

The investigators for the study and the authors of this report are Robert W. Cook, Ph.D., Assistant Professor and Chairman, Department of Economics, and Thomas J. Cosse, Ph.D., Associate Professor of Marketing and Associate Dean, both of The E. Claiborne Robins School of Business, University of Richmond.

## Methodology

The data for this study were obtained from two sources: optometrists practicing in Virginia and from major third-party providers in the Commonwealth.

A mail survey of optometrists was undertaken during November and December, 1985. On November 20, 1985, mail questionnaires were sent to all 518 persons believed to be practicing optometry in the state of Virginia. The names and addresses were provided by the Virginia Optometric Association. A follow-up mailing to those individuals who had not responded to the November request was made on December 10. Optometrists were asked to indicate the number of patients diagnosed as having each of ten eye conditions (at two levels of severity) during the months of August, September, and October 1985, the office visit fee for such a diagnosis and the fee that would most likely be charged if the optometrist were authorized to treat each condition. A summary of questionnaire returns is reported in Table I.

The responses were tabulated by condition treated, savings per condition diagnosed and treated, and total savings for all conditions diagnosed and treated.

The estimated number of patients diagnosed in 1985 is the sum of those patients diagnosed by responding optometrists during August, September and October 1985 multiplied by four. The data was not seasonalized as there is no smoothing factor available for this industry. Table II includes the totals by condition as well as the total number of patients diagnosed.

The cost of diagnosis and treatment was determined in a similar manner. The fees listed by each optometrist were multiplied by the number of patients diagnosed and treated and annualized by multiplying by four. There was no attempt made to seasonalize the total fees charged. Savings were computed by multiplying the average fee charged by ophthalmologists for diagnosis and treatment for each condition by the annualized number of patients diagnosed and treated by optometrists. The estimated charges for diagnosis and treatment by ophthalmologists were deducted from the estimated charges for diagnosis and treatment by optometrists and the difference is reported by condition and as a total in Table III.

**TABLE I**  
**SUMMARY OF QUESTIONNAIRE RETURNS**

Total Questionnaires Mailed (Survey Population)	518
Questionnaires Accounted For:	
Usable Questionnaires Returned by Postal Service	280
(Due to Incorrect Address)	6
Unusable Questionnaires Returned (Unusable due to improperly and/or incomplete answers)	21
Questionnaires Returned by Ineligible Respondents	<u>39</u>
Total Questionnaires Accounted For	346
Total Questionnaires Not Accounted For (Nonresponse - Population Less Questionnaires Accounted For)	172
Adjusted Survey Population (Population Less "Ineligible Respondents": 518-39)	479
Response Rate (Usable Questionnaires Divided By Adjusted Survey Population: 280/479)	58.5%

\*Ineligible respondents include questionnaires returned by military/government optometrists, optometrists no longer in practice, optometrists practicing out of state and one ophthalmologist incorrectly included in mailing list.

TABLE II

## ESTIMATED NUMBER OF PATIENTS DIAGNOSED: 1985

<u>Condition</u>	<u>Patients</u>
Corneal Abrasion	
Minor	2,302
Severe	461
Corneal Ulcer	
Minor	406
Severe	92
Corneal Foreign Body	
Minor	1,267
Severe	228
Conjunctivitis	
Minor	3,515
Severe	643
Blepharitis	
Minor	1,901
Severe	304
Flash Burns	
Minor	166
Severe	29
Chalazion	
Minor	1,192
Severe	248
Subconjunctival Hemorrhage	
Minor	1,098
Severe	193
Iritis	
Minor	415
Severe	98
Glaucoma	886
Acute Glaucoma Attack	<u>35</u>
 Total Patients	 15,479



TABLE III

ESTIMATED SAVINGS OF DIAGNOSIS AND TREATMENT:1985

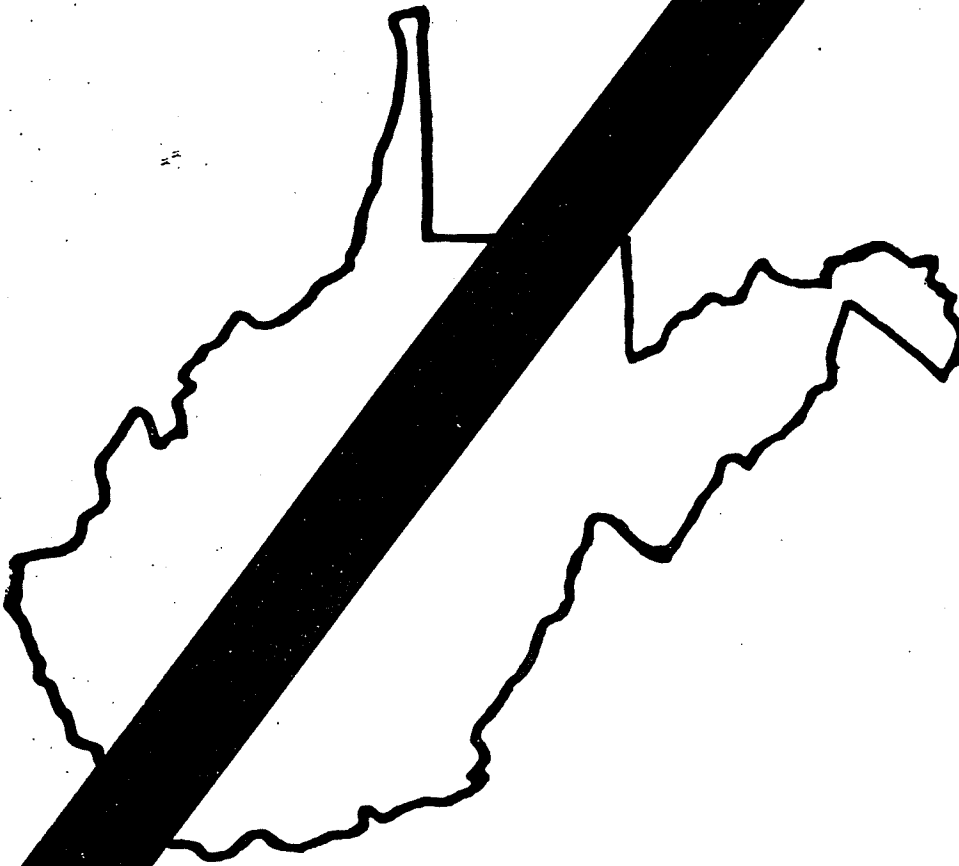
<u>Condition</u>	<u>Savings</u>
Corneal Abrasion	
Minor Diagnosis	\$234,892
Minor Treatment	105,784
Severe Diagnosis	89,544
Severe Treatment	40,712
Corneal Ulcer	
Minor Diagnosis	42,676
Minor Treatment	13,116
Severe Diagnosis	18,100
Severe Treatment	7,068
Corneal Foreign Body	
Minor Diagnosis	129,952
Minor Treatment	56,360
Severe Diagnosis	44,516
Severe Treatment	17,840
Conjunctivitis	
Minor Diagnosis	363,844
Minor Treatment	193,752
Severe Diagnosis	127,240
Severe Treatment	59,348
Blepharitis	
Minor Diagnosis	189,380
Minor Treatment	118,236
Severe Diagnosis	58,948
Severe Treatment	31,068
Flash Burns	
Minor Diagnosis	15,896
Minor Treatment	8,648
Severe Diagnosis	5,684
Severe Treatment	3,008
Chalazion	
Minor Diagnosis	123,140
Minor Treatment	75,960
Severe Diagnosis	51,956
Severe Treatment	24,860
Subconjunctival Hemorrhage	
Minor Diagnosis	119,140
Minor Treatment	104,504
Severe Diagnosis	38,572
Severe Treatment	28,024
Iritis	
Minor Diagnosis	41,328
Minor Treatment	16,920
Severe Diagnosis	19,524
Severe Treatment	8,560

Glaucoma	
Diagnosis	148,012
Treatment	66,520
Acute Glaucoma Attack	
Diagnosis	5,656
Treatment	<u>3,184</u>
TOTAL SAVINGS	\$2,851,472

# **OPTOMETRY**

## **1983**

A Post Facto Report on  
Enr. H.B. 1005 (1976)



Developed and Presented by  
The West Virginia  
Optometric Association

# WEST VIRGINIA BOARD OF OPTOMETRY

JOHN E. CASTO, O.D.

SECRETARY TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY

511 SIXTH AVE.

P.O. BOX 710

ST. ALBANS, W.VA. 25177



January 25, 1983

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

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

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

Dear President McGraw and Speaker See:

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

Recent information compiled from the one hundred eighty-three (183) West Virginia registered optometrists now certified by this Board for drug usage is as follows:

1. A total of seventy-four (74) different drugs prescribable for the human eye have been employed by these West Virginia certified optometrists since the law was enacted.
2. Over one hundred thousand (100,000) individual patients have been seen by these optometrists and conditions such as infectious or allergic conjunctivitis, corneal abrasions, and blepharitis (granulated eye lids) have been treated by those certified in the compilation. This does not include the use of topical anesthetics used routinely by most of these optometrists in performing tonometry (glaucoma test). It is estimated that some one and one quarter million (1,250,000) patients have been administered a topical anesthetic for this testing procedure.

The Honorable Warren R. McGraw  
The Honorable Clyde M. See, Jr.  
January 25, 1983  
Page 2

3. The distance those patients, who otherwise would have had to travel to geographical locations other than those of the treating optometrist for treatment by appropriate medical specialties to whom they formerly were referred, would have been required to travel is nearly one million eight hundred thousand miles (1,800,000).

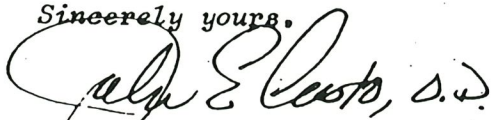
4. Fifty-three (53) different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

These 183 West Virginia optometrists who have been certified in every county of the state are now, faithfully and well, providing updated eye health care benefits to the people of West Virginia.

It should be additionally noted that there has been no report to this Board of any unusual adverse drug reaction to patients where drugs were administered.

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

Sincerely yours,



John E. Casto, O.D.  
Secretary-Treasurer  
West Virginia Board of Optometry



# THE WEST VIRGINIA OPTOMETRIC ASSOCIATION



OFFICE OF THE PRESIDENT

March 4, 1983

Dear Legislator:

House Bill 1005 became law in 1976 authorizing doctors of optometry to utilize diagnostic and therapeutic pharmaceutical agents upon the anterior segment of the eye.

This law has had tremendous impact upon the citizens of West Virginia during the last seven years, and this report is designed to demonstrate that the constructive changes in the legal definition of optometry have served the people of West Virginia as was the intent of the legislature.

Presently, there are two hundred (200) doctors of optometry licensed in West Virginia and of those one hundred eighty-three (183) are drug certified by the West Virginia State Board of Optometric Examiners. This means that these doctors of optometry have satisfactorily completed pharmacology courses and the clinical application of those courses either in school or as postgraduate study and that the Board of Optometry has examined these doctors and certified their competency.

This places the citizens of West Virginia geographically much closer to a health professional who can treat an eye disease or stabilize, through drug treatment, a vision threatening eye emergency. Not only has this saved West Virginians money through decreased travel but it has saved countless hours and undoubtedly numerous eyes.

No doubt, this year as in previous years you will be receiving or have received ophthalmological publications such as the "Pen" letter claiming that individuals in West Virginia have been damaged by non-medically trained doctors, however, to date the State Board of Optometry relates that they have not been notified of a single malpractice case against a doctor of optometry resulting from drug treatment.

In regard to the statement that doctors of optometry are not medically trained, I would only indicate that all medical training is not done at a medical school, in fact, doctors of optometry, osteopaths, chiropractors, dentists, podiatrists, and others all have medical training without attending medical school as such. However, they are required to take courses in biochemistry, anatomy, physiology, and pharmacology among others. Many of these professions without training in medical schools utilize drugs to a much greater extent than doctors of optometry.

There are two times as many optometrists in the nation as ophthalmologists and three times as many optometrists in West Virginia as oph-

West Virginia Legislators  
March 4, 1983  
Page 2

thalmologists. The information relating to the distribution geographically of ophthalmologists and optometrists in West Virginia is included graphically in this report.

In closing, I feel that doctors of optometry truly serve the visual needs of the citizens of West Virginia and I hope that this introductory letter outlines what West Virginia's accomplishments have been through your efforts and what we must continue to do together in the future.

Sincerely,

A handwritten signature in cursive script that reads "H. Alexander Hereford". The signature is written in dark ink and is positioned to the right of the typed name.

H. Alexander Hereford, O.D.  
President

HAH/scp

# Kansas Optometric Association

400 Kansas Ave. Suite A, Topeka, KS 66603  
913-232-0225

## TESTIMONY

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

MARCH 30, 1987

*Peter*

I am Peter Brungardt, a practicing optometrist from Salina. It is my pleasure to represent over 300 Kansas optometrists. Our association represents over 95% of the practicing optometrists in Kansas.

I would like to discuss the education of optometrists and their training as concerns this bill. Secondly, I would like to talk with you about the clinical experience of optometrists.

I wish to briefly address the drugs and conditions we wish to treat. Finally, we can briefly discuss some of the arguments and tactics used by the opposition in other states.

#1  
Optometric education is basically a four year post graduate curriculum based on basic biological sciences and studies of the physical and optical properties of light. These various fundamental subjects are coordinated into specific training for the treatment of eyes and vision. Please refer to the handout from the State University of New York. This school is chosen as it has colleges of optometry, medicine and dentistry in the same university. The first page details pre-admission requirements. The next three pages summarize the professional training in each discipline. Obviously, differences exist as concerns the specifics of each profession. The obvious point, however, is that

*Attn #2-  
3-30-87  
PXRW*



the undergraduate and professional training programs are comparable and result in doctoral level degrees. All optometric schools are fully accredited. In several of these schools, basic courses are taught to students in each program in identical fashion. Please refer to your handout detailing pharmacology instruction from the University of Indiana.

As you can see in the highlighted portions of this article optometric and medical students are taught by the same people over the same material.

Please refer next to the article "Pharmacology Training in Schools, A Comparative Analysis." This document reports on the classroom and clinical hours of exposure in several schools of medicine, dentistry and optometry. The second page summarizes the hours in graph form. Again, obvious excellent education is afforded the optometric student.

The next handout is a letter from Dr. Les Walls in Oklahoma. Dr. Walls is an optometrist and a physician. He teaches family practice residents in training. On the second page we have highlighted his analysis of optometric education relative to its differences from medical training.

Optometry laws have existed for only about sixty years. The changes involved in our education have been dramatic as a result of that brief time frame. We have prepared another handout summarizing the changes in optometry at the University of Houston from 1968 to 1985. As you can see, the requirements in basic science studies have increased steadily. The other significant change is in the added clinical opportunities during training.

Clinical exposure begins in the second year. The last pages of this section list the opportunities now available for exposure in disease treatment and management. Optometry students receive externships in a variety of clinical settings which allow them to monitor a wide range of medical conditions affecting the eye.

The last point in education involves the excellent continuing education available to optometrists through journals, books, seminars and continuing education courses. For example, about 200 optometrists took a 100 hour transcript quality course on ocular therapeutics last fall. This instruction was provided by Ph.D.'s, physicians and pharmacists, as well as optometrists.

The second major point to consider in your understanding of optometry concerns the clinical experience of practicing doctors of optometry. Those of us in practice have a high level of knowledge in the diagnosis and management of anterior eye difficulties. For example, contact lens practice is basically the maintenance of corneal health in the presence of a lens which is a foreign object. This involves mechanical and physiological impairment to the front of the eye. Optometry is very comfortable with the management of these problems. We have the necessary biomicroscope and clinical expertise to make the appropriate identification of various problems.

In the case of all infections, for example, we have been making the diagnosis and referring the patient to an appropriate physician for a medication. Further, we have been following these patients as their conditions resolve. The discussion with the consulting physicians as these problems resolve, give optometrists

good depth of clinical knowledge needed for treatment and management of anterior eye disease.

In the case of foreign body removal, optometry is very well versed in the various levels of corneal anatomy. We understand the complications and characteristics involved in management of these problems. The equipment and knowledge needed to manage, treat or refer corneal foreign material is familiar ground for the optometrist.

The current resolution of red eye difficulties is worthy of your review. Typically, if a patient contacts a primary care physician with complaints of a red eye, with discharge and light sensitivity, the normal course of action involves the prescription of medication to be taken for three to five days. If improvement is not achieved, the patient will be examined. A few points are worthy of note. An exact diagnosis isn't attempted because the primary physician does not have a biomicroscope necessary to differentiate conjunctivitis from keratitis or iritis. Further, the medication is often a steroid-antibiotic combination. This will help patient symptoms most of the time. However, in certain infections, steroids can make the condition worse. The relative safety of this course of treatment is normally satisfactory. The optometric examination and subsequent re-exam with proper equipment and diagnostic expertise will raise the level of care available to Kansans. I don't wish to criticize the care described by primary care medicine. The point is simply to acquaint you with the current standard of care. Senate Bill 113 will raise the level of treatment in both safety and efficacy when provided by an

optometrist.

We have discussed optometric education, clinical experience and standard primary care. I would now like to discuss the rationale for this bill. As the eye care practitioners for most Kansans, we should ideally treat common, acute and troublesome conditions when possible. As primary care eye doctors, optometrists should manage "most of our patients problems most of the time." We wish to employ medications on the surface of the eye to treat conditions limited to the eye. The conditions that signify systemic disease or long term eye disease will be referred to the appropriate medical specialty. This doesn't change from current practice. We have limited the use of steroids, for example, to address only those short term inflammations appropriate to primary care. Ophthalmology is and will continue to be the provider of specialty care in eye care.

Let's take a moment to discuss steroids. These medications affect the inflammatory response of the body. Their use on the eye causes symptoms of redness, pain and swelling to be dramatically reduced. The eye becomes white and comfortable with their use. These drugs are important as they make people comfortable while they are healing. The side effects of steroids are numerous and should be treated with appropriate respect. For example, certain people may develop higher eye pressure or cataracts. Also, the hormonal system of the body is affected. Naturally, optometrists would re-examine patients under treatment. The optometric use of these medications will be judicious. We will be alert for these side affects. The single biggest problem

with topical ocular steroids is their improper use in herpes virus infections of the cornea. This particular condition is made worse when a steroid is used. The diagnosis of this condition is made with the biomicroscope or slit lamp. Again, the optometric use of therapeutics will raise the level of care as most primary physicians don't have biomicroscopes or the clinical means to make this distinction. We are well aware of the benefits and drawbacks of all the medications for use in primary care. Our patients should not be denied the comfort steroids can provide when needed. They should not require secondary referral for common problems.

Lastly, I would like to discuss some of the approaches and tactics used by medicine in other states. Ophthalmology has made allegations and charges of mistreatment in other states where this legislation has been considered. They relate to some number of cases of supposed misdiagnoses or mistreatment. Time after time, these allegations were distorted or groundless. These cases are often never reported to the state licensing board for optometrists. A small percentage of bad results unfortunately occur in any profession. Neither ophthalmology nor optometry has chosen to resort to these tactics in Kansas. We are responsible for diagnosis at present -- on the same standard as other practitioners. Misdiagnosis is the cause of most serious problems in patient care. In the Senate hearings, reference was made to a Dr. Weinstein and his allegations of mistreatment by West Virginia optometrists of some 40 cases. We asked the optometric licensing board in that state, but they have no knowledge of these anecdotes.

In fact, they had previously requested documentation from Dr. Weinstein, but received no reply. A similar argument involves the "worst case" scenario. The possibility of an overly aggressive optometrist causing harm is intended to scare the legislator. Our point is simply that as responsible clinicians we must continue to make the needed decisions in patient care.

Finally, medicine will attempt to demonstrate their desire to help. Since these issues are technical and legislators are laymen, they may propose a study commission, board or committee to study and/or implement needed changes. I would point out that medicine has had plenty of opportunities to affect reasonable change. They have resisted all change. These committees all have the built in problem of medical dominance so that implementation won't occur.

E We have given you a wealth of material to read. I've included one last addendum from ophthalmology's transcript of Dr. Jack Walker's comments from the first negotiating session. 7 I would encourage you to spend a few minutes in review of his comments. I think he has a unique perspective as a medical educator and health care administrator.

Optometry can only update our techniques and practice acts by the legislative changes in law. Medicine can adopt new treatments, medications and procedures as they wish. Their basic freedom is self-controlled. Optometry is limited in our scope by law. We must return to the legislature for change in our law. We have shown you the qualifications of current optometry. We have shown the increased convenience and better level of care available to our

patients. Optometric practice is overwhelmingly approved by Kansas citizens. We deliver most of the eye care in Kansas. Our patients come to us with eye problems of all types. We need the means to relieve those primary difficulties.

I urge you to vote for Senate Bill 113 as did the Kansas Senate in a 34-4 vote a few weeks ago. The Senate counterpart of this Committee studied this measure for two years. They amended the bill significantly so that it now represents a good middle ground.

Appendix I

TYPICAL PREPROFESSIONAL EDUCATIONAL REQUIREMENTS  
FOR OPTOMETRY, DENTISTRY, AND MEDICINE

	<u>OPTOMETRY</u> <sup>1</sup>	<u>DENTISTRY</u> <sup>2</sup>	<u>MEDICINE</u> <sup>3</sup>
Minimum pre professional training	3 yrs.	3 yrs.	3 yrs.
English	1 yr.	1 yr.	1 yr.
Inorganic Chemistry	1 yr.	1½ yr.	1 yr.
Organic Chemistry	½ yr.	1 yr.	1 yr.
Physics	1 yr.	1 yr.	1 yr.
Biology or Zoology	1 yr.	1 yr.	1 yr.
Differential Calculus	½ yr.	--	--
Psychology	1 yr.	--	--
Social Science	1 yr.	--	--
Statistics	½ yr.		

1. State University of New York, State College of Optometry Catalog 1984-86.  
Pg. 64.
2. New York University Bulletin 1984-85, College of Dentistry. Pg. 18.
3. New York University School of Medicine, 1986, Information for Applicants.  
Pg. 3.

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APPENDIX II  
TYPICAL PROFESSIONAL PROGRAMS IN  
OPTOMETRY<sup>1</sup>, DENTISTRY<sup>2</sup>, AND MEDICINE<sup>3</sup>

First two years

<u>OPTOMETRY</u>	<u>DENTISTRY</u>	<u>MEDICINE</u>
Histology Physiology Gross Anatomy Cell Biology	Histology Physiology Gross Anatomy	Histology Physiology Gross Anatomy Cell Biology
Microbiology General Pharmacology General Pathology	Biochemistry Microbiology Pharmacology Pathology	Biochemistry Microbiology Pharmacology General & Systemic Pathology Neurosciences:
Neuroanatomy	Neuroscience	Neurophysiology Neurochemistry Neuropathology Intro to Clinical Neurology
Nutrition Public Health	Nutrition Behavioral Sciences and Community Health	Behavioral Sciences
Human Development	Inheritance & Devlpmt.	Genetics
Clinical Diagnosis Ocular Anatomy	Principles of Human Behavior	Human Sexuality
Human Vision	Humanities	Epidemiology Medical Ethics Physical Diagnosis
Ocular Physiology	Physical Diagnosis	Embryology
Ocular Biochemistry	Materials Science	Immunology
Ocular Pathology	Normal Mastication	Intro to Clinical Sciences
Perceptual Devlpmt.	Life Support & Cardio Pulmonary Resuscitation	Parasitic Diseases
Geometric Optics Physiological Optics Visual Perception Physical Optics Binocular Vision Refractive Error Strabismus & Amblyopia Accommodation, Convergence Contact Lenses		
Ophthalmic Optics		
Optometric Methods (includes beginning patient care)		

Appendix II - cont'd - TYPICAL PROFESSIONAL PROGRAMS IN  
OPTOMETRY, DENTISTRY, AND MEDICINE

Third year

	<u>OPTOMETRY</u>	<u>DENTISTRY</u>	<u>MEDICINE</u>
	Ocular Pharmacology	General and Oral Medicine	CLINICAL CLERKSHIPS: (Bedside Instruction)
	Contact Lenses		
	Functional Visual Analysis	Detection & Treatment of Oral and Facial Cancer	Surgical
	Vision Training	Cariology	Obstetrical and Gynecological
	Geriatric Optometry	Behavioral Sciences	Medical
	Behavioral Vision Analysis	Community Health	Pediatric
	Care of the Partially Sighted	Clinical Pathology	Psychiatric and Neurological
	Ocular Pathology	Humanities	
	Ophthalmic Optics	Endodontics	
	Epidemiology	Fixed Prosthodontics	
	Behavior modification	Occlusion	
	Tests and Measure- ments	Operative Dentistry	
	Public Health	Oral and Maxillifacial surgery	
	Clinical Methods (11 hours per week of supervised patient care at the University Optometric Center	Oral Diagnosis	
		Orthodontics	
		Pedodontics	
		Penodontics	
		Radiology	
		Removable Prostho- dontics	
		Nutrition	

Appendix II - cont'd - TYPICAL PROFESSIONAL PROGRAMS IN  
OPTOMETRY, DENTISTRY, MEDICINE

Fourth year

	<u>OPTOMETRY</u>	<u>DENTISTRY</u>	<u>MEDICINE</u>
	Bioelectronics (elective)	Family Practice Program	Two-month Junior Internship in speci- fic Clinical
	Senior Research (elective)	Elective courses in Basic and Clinical Services	Disciplines at NYU School of Medicine
	Contact Lenses		Remaining 6 months:
	Illumination (elective)		Free Elective Period
	Emergency Care		Research or clinical Programs at scienti- fic institutions and hospitals in US and abroad
	Psychodynamics of patient care		
	Behavior Modifica- tion Practicum		
	Special Testing (elective)		
	Practice Administra- tion		
	Clinical Care Study Seminar		
	Research Methods		
	Ocular Pathology		
	Developmental Disabilities		
	Public Health		
	Learning Disabilities		
	Clinical Internships - (20 hours per week of supervised clinical care on patients at the University Optometric Center)		

1. State University of New York, State College of Optometry Catalog 1984-86.  
Pg. 64.
2. New York University Bulletin 12984-85, College of Dentistry. Pg. 18.
3. New York University School of Medicine, 1986, Information for Applicants.  
Pg. 3.

# Comparison of Pharmacology Courses for Optometry and Medical Students, Indiana University, Bloomington

Sally Hegeman, Ph.D.

An argument is made by various medical organizations that optometrists are not adequately trained to use drugs for diagnostic or therapeutic purposes. Because many of these arguments arise from a lack of information about the pharmacology training for the optometrists, the following comparison and evaluation of the course of study taken by Indiana University optometry students, with that taken by medical students in the Medical Sciences Program, Bloomington, was undertaken. The Medical Sciences Program, which is part of the Indiana University School of Medicine, provides preclinical training to 30 students in each of the first two years. Because of the emphasis on academic medicine, a number of these students are pursuing an M.S. or Ph.D. degree in one of the basic medical sciences. The pharmacology program at Indiana University School of Optometry has been in existence with minor revisions since 1977.

Sally Hegeman, Ph.D., is assistant professor of optometry and adjunct assistant professor of pharmacology, Indiana University School of Optometry and Indiana University Medical Sciences Program, Bloomington

## General Information

The medical pharmacology course, which is taken by 30 second year medical students, meets four hours per week for two semesters, or 30 weeks. Three or four examinations are given in each semester along with a comprehensive final examination at the end of each semester. The exams are multiple choice and short essay. Seventy third year optometry students take five lecture hours per week of general systemic pharmacology the first semester and three hours per week the second semester. The examinations have the same format as those for medical students; however, they do not have a comprehensive final examination. Often the same examination is given to both the optometry and the medical students. When this is done, overall performance is the same; i.e., median and means for both groups are within 1 to 2 points of each other.

The textbooks for both the medical and the optometry classes vary from year to year. For the 1982-83 academic year both used C.R. Craig and R.E. Stitzel's *Modern Pharmacology* (Boston: Little, Brown & Co., 1982) as the basic text. In the past five years A. Goodman, L.S. Goodman, and A. Gil-

man's *The Pharmacological Basis of Therapeutics*, 5th or 6th ed. (New York: Macmillan, 1975 or 1980) has been the most frequently adopted text in the medical program. That same textbook and A. Goth's *Medical Pharmacology*, 9th and 10th ed. (St. Louis: C.V. Mosby, 1978 and 1981) have been used in alternate years in the optometry course. In addition, W.H. Havener's *Ocular Pharmacology* (St. Louis: C.V. Mosby, 1978) is a required text for optometry students.

## Faculty

The medical pharmacology course is taught by five pharmacology faculty members from the Indiana University School of Medicine Medical Sciences Program. Each member is responsible for six weeks of lectures. The optometry course is taught by four or five faculty members, three of whom teach in the Medical Sciences Program pharmacology course. These three faculty members are responsible for the majority of training in general pharmacology for the optometry students. Ocular pharmacology is taught by an optometrist-pharmacologist who is a faculty member of both the Indiana University School of Optometry and the Medical

Sciences Program. The fifth instructor teaches medical and pharmacy students at another university.

### Content

The content of the two courses as taught in the 1981-82 academic year is summarized in the accompanying table.

As can be seen from Table 1, 58 hours (footnotes b and c) of optometry instruction are the same as for medical students (Indiana University, Bloomington, or other medical schools), and 25 hours (footnote a) are very similar.

Thirty-seven hours are devoted to ocular pharmacology for optometry students only.

### Conclusion

Approximately two-thirds of the pharmacology training of optometry and medical students is the same. The one-third difference between the groups is determined by their respective professional requirements. Optometry students have more intensive training than medical students in autonomic agents, local anesthetics, ocular basic principles, and bacterial, fungal, and viral chemo-

therapy, especially as they apply to the eye. Medical students have more intensive training in toxicology and in cardiovascular and central nervous system pharmacology than optometry students. In addition, the medical students study gastrointestinal pharmacology, cancer chemotherapy, and treatment of worms and protozoal infections which are not included in the optometry curriculum. Thus, the optometry student receives special training in ocular pharmacology and the medical student obtains the necessary breadth and depth to meet his career needs. □

TABLE 1  
Content of Medical and Optometry Pharmacology Courses

Subject	Lecture Hours	
	Medicine	Optometry
Basic Principles—Systemic	12	12 <sup>a</sup>
Basic Principles—Ocular		5
Autonomic Agents—Systemic	14	14 <sup>b</sup>
Autonomic Agents—Ocular		10
Cardiovascular Agents	10	4 <sup>c</sup>
Renal Agents—Systemic	4	3 <sup>a</sup>
—Use in Ocular Disease		1
Chemotherapy (bacterial, viral, fungal)—Systemic	12	12 <sup>b</sup>
—Ocular Chemotherapy		9
Chemotherapy (cancer, protozoan, worms, etc.)	10	0
Toxicology—Systemic	8	2 <sup>c</sup>
—Ocular		2
Steroids, Anti-Inflammatory—Systemic	5	4 <sup>b</sup>
—Ocular		2
Non-steroidal Anti-Inflammatory	4	4 <sup>a</sup>
Local Anesthetics—Systemic	2	2 <sup>a</sup>
—Ocular (topical) Anesthetics		2
Narcotic Analgesics	4	4 <sup>a</sup>
CNS	20	10 <sup>b</sup>
Endocrine	10	10 <sup>b</sup>
GI	3	0
Drug Interactions	2	2 <sup>b</sup>
Vitamins	0	3
Ocular Manifestations of Systemic Drug Administration	0	3
Total Lecture Hours	120	120

<sup>a</sup>Lecturer different for the two courses, but lecturer taught material to medical students within last five years.

<sup>b</sup>Same lecturer and lectures for medicine and optometry.

<sup>c</sup>Teaches same block of material to medical students at another university.

Lesley L. Walls, O.D., M.D.  
Post Office Box 78  
Glenpool, Oklahoma 74033

February 19, 1986

Honorable Roy Ehrlich, Chairman  
Senate Public Health and Welfare Committee  
State House  
Topeka, Kansas 66612

Dear Senator Ehrlich:

I am writing you in support of Senate Bill 651 which would broaden the scope of practice for optometrists in the State of Kansas. I know this topic is an emotional issue, however, I feel that careful review of other states, etc. will substantiate the fact that with proper education and training it is safe. As well, in the present day of astronomical health care costs I feel it is cost efficient. I also feel that with such a law it can be demonstrated that better and more appropriate referrals to physicians will be made by optometrists.

I write to you with a personal background of graduating from both optometry school and medical school. I am very comfortable presently and have no axe to grind, rather simply wish to express my personal opinion.

Let me now address some specific aspects of optometric and medical education by my own first hand experience.

Medical school traditionally prepares the student in general medical and surgical background for post-graduate training programs. Detailed anatomy and physiology of organs such as the eye is not emphasized during medical school. As well, during surgical rotation in medical school it is uncommon to be exposed to ocular surgery. Because heart disease, cancer, and stroke are the biggest killers of the U.S. population, medical school clinical training is heavily devoted to general internal medicine, general surgery, obstetrics--gynecology and pediatrics. There are usually fourth-year electives in 4-12 week blocks where a student may increase his/her exposure to subspecialty medical and surgical areas such as: ophthalmology, ear/nose and throat, urology, pulmonary medicine, cardiology, etc. In my experience a small minority of students choose ophthalmology as a clinical rotation.

By a small personal survey in the area of Oklahoma in which I reside, most primary care physicians (general practitioners, family practice, internists, and pediatricians) state they had from one to three weeks of medical school devoted to ophthalmological care. This includes both didactic coursework and clinical experience. I do not need to remind you that these physicians treat eye diseases on an unrestricted basis.

*LLW*  
~~LLW~~  
3-30-87

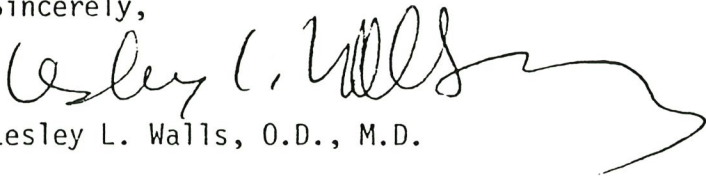
On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. The detailed ocular anatomy, 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.

Secondly, I will discuss my personal experience with side effects of ocular pharmacologic therapy. This section will be very brief as I have never had a patient with anything other than a very minor side effect from ocular pharmaceutical agents. I have seen a few mild allergic reactions and none of these serious and none had any evidence of systemic reactions such as elevated blood pressure, rapid heart rate, arrhythmias of the heart, etc. None ever required hospitalization and certainly there were no deaths. I have seen very few significant side effects and all which have occurred were very minor in nature.

In summary I would like to point out that ophthalmologists are vitally needed. The medical profession would be in sad shape without them because of their expertise in the area of ocular trauma, cataract surgery, retinal surgery, serious ocular infections, etc. However, in a rural state the ophthalmologists are primarily in large and medium sized cities with a poor distribution in the rural communities.

I also strongly feel that optometrists are vitally needed. Optometrists are well distributed in rural communities and by definition serve as primary care professionals. In my opinion, the patient, particularly in the rural areas and small town, will be the beneficiary of modern optometric practice. With the use of pharmaceutical agents, disease detection will be facilitated thus making the referral system into medicine more efficient. As well, this will save the patient a lot of inconvenience and time. I feel optometrists should be allowed to practice modern optometry which includes therapy with various pharmaceutical agents. I believe the key to utilizing these medications by any health care professional is proper education and training.

Sincerely,



Lesley L. Walls, O.D., M.D.

LLW/laj

# Kansas Optometric Association

## OPTOMETRIC EDUCATION 1963 TO 1985

### PRE-OPTOMETRY MATH AND SCIENCE REQUIREMENTS

#### 1967-68

BIOLOGY - 8 HRS.  
CHEMISTRY - 8 HRS.  
MATHEMATICS - 6 HRS.  
PHYSICS - 8 HRS.  
PSYCHOLOGY -  $\frac{0}{30}$  HRS.  
30 HRS. TOTAL

#### 1977-78

BIOLOGY - 8 HRS.  
CHEMISTRY - 13 HRS. (GENERAL, ORGANIC)  
BIOCHEMISTRY - 5 HRS  
MATHEMATICS - 6 HRS. (CALCULUS)  
PHYSICS - 9 HRS.  
PSYCHOLOGY -  $\frac{3}{44}$  HRS.  
44 HRS. TOTAL

#### 1984-85

BIOLOGY - 16 HRS.  
CHEMISTRY - 16 HRS. (GENERAL, ORGANIC)  
BIOCHEMISTRY - 5 HRS  
MATHEMATICS - 7 HRS.  
PHYSICS - 3 HRS.  
PSYCHOLOGY -  $\frac{6}{56}$  HRS.  
56 HRS. TOTAL



# Kansas Optometric Association

## OPTOMETRY SCHOOL HEALTH SCIENCES CURRICULUM

1957-58

### HEALTH SCIENCES

1. HUMAN ANATOMY & PHYSIOLOGY	8 HRS.
2. ANATOMY & PHYSIOLOGY OF VISION SYSTEM	4 HRS.
3. GENERAL OCULAR PATHOLOGY	10 HRS.
4. OCULAR BIOCHEMISTRY AND PHARMACOLOGY	2 HRS.
	<u>24 HRS.</u> TOTAL

1977-78

### HEALTH SCIENCES

1. HUMAN ANATOMY HISTOLOGY & PHYSIOLOGY	8 HRS.
2. NEUROANATOMY & NEUROPHYSIOLOGY	4 HRS.
3. OCULAR ANATOMY & PHYSIOLOGY	12 HRS.
4. GENERAL & OCULAR PHARMACOLOGY	6 HRS.
	<u>35 HRS.</u> TOTAL

1984-85

HEALTH SCIENCES - REDUCTION IN TOTAL HRS. WAS POSSIBLE BECAUSE OF HEAVY PRE-OPTOMETRY EMPHASIS ON SCIENCE.

1. OCULAR ANATOMY & PHYSIOLOGY - NEUROANATOMY & NEUROPHYSIOLOGY WITH LABORATORY IN OCULAR HISTOLOGY	9 HRS.
2. FUNDAMENTAL PATHOLOGICAL PROCESSES, HUMAN IMMUNOLOGY & GENERAL PHARMACOLOGICAL PRINCIPLES WITH LABORATORY COVERING EMERGENCY PROCEDURES	6 HRS.
3. OCULAR PHARMACOLOGY & THERAPEUTICS - OCULAR MANIFESTATIONS OF SYSTEMIC DISEASE & LABORATORY COVERING ADVANCED DIAGNOSTIC TECHNIQUES & THE USE OF DIAGNOSTIC DRUGS	5 HRS.
4. SELECTED TOPICS IN OCULAR PATHOLOGY INCLUDING DISEASES OF THE CORNEA, SCLERA, LENS, UVEAL TRACT & GLAUCOMA - DISEASES OF THE RETINA	6 HRS.
5. EPISTEMOLOGY AND PATTERNS OF DISEASE OCCURENCE OCULAR DISEASES OF GENETIC ORIGIN AND ACUTE OCULAR EMERGENCIES	3 HRS.
	<u>29 HRS.</u> TOTAL

Affiliated with  
American Optometric Association

# Kansas Optometric Association

EACH FOURTH YEAR STUDENT SPENDS 16 WEEKS AT ONE OF THE FOLLOWING SITES UNDER THE SUPERVISION OF REGULAR OR ADJUNCT FACULTY. THESE SITES HAVE BEEN SELECTED BECAUSE OF THE NUMBER OF PATIENTS AVAILABLE, THE VARIETY OF VISION AND GENERAL HEALTH PROBLEMS, AND BECAUSE THERE IS A BROAD RANGE OF PRIMARY HEALTH CARE OFFERED IN CONJUNCTION WITH OPTOMETRIC CARE. OPHTHALMOLOGIST ARE INVOLVED IN MOST OF THE CLINICS TO PROVIDE EDUCATIONAL SUPPORT.

BROOKE ARMY MEDICAL CENTER, SAN ANTONIO, TEXAS

CORPUS CHRISTI NAVAL REGIONAL MEDICAL CENTER, CORPUS CHRISTI, TEXAS

DARNELL ARMY HOSPITAL, FT. HOOD, TEXAS

FT. CARSON HOSPITAL, COLORADO SPRINGS COLORADO

FT. POLK HOSPITAL, LOUISIANA

FOURTH WARD CLINIC, HOUSTON

INDIAN HEALTH SERVICE HOSPITAL, FT. YATES, NORTH DAKOTA

INDIAN HEALTH SERVICE HOSPITAL, SANTA FE, NEW MEXICO

IRWIN ARMY HOSPITAL, FT. RILEY, KANSAS

MARTIN ARMY HOSPITAL, FT. BENNING, GEORGIA

NAVY REGIONAL CLINIC, NEW ORLEANS, LOUISIANA

OPTOMETRIC CENTER OF ST. LOUIS, ST. LOUIS, MISSOURI

REYNOLDS ARMY HOSPITAL, FT. SILL, OKLAHOMA

RICHMOND STATE SCHOOL, HOUSTON

SAN JOSE CLINIC, HOUSTON

SOUTHWESTERN INDIAN POLYTECHNIC INSTITUTE HEALTH CENTER,  
ALBUQUERQUE, NEW MEXICO

UNIVERSITY OF HOUSTON-DOWNTOWN, HOUSTON

VISION EDUCATION FOUNDATION DIAGNOSTIC CENTER, ATLANTA, GEORGIA

WALTER REED MEDICAL CENTER, WASHINGTON, D.C.

WILLIAM BEAUMONT ARMY HOSPITAL, EL PASO, TEXAS

# Kansas Optometric Association

THIS PROGRAM IS OVER AND ABOVE THE SIGNIFICANT CLINICAL TRAINING THE STUDENTS RECEIVE IN THE OPTOMETRY SCHOOL. BEGINNING IN THE FIRST YEAR THE STUDENTS START SEEING PATIENTS IN THE CLINIC. THIS INVOLVES APPROXIMATELY 500 HRS. OF CLINICAL TRAINING DURING THE 4 YR. CURRICULUM. FOUR OPHTHALMOLOGISTS PARTICIPATE IN DIDACTIC AND CLINICAL TRAINING AT THE COLLEGE IN ADDITION TO THE OPTOMETRIC FACULTY. IN 1968 THERE WERE NO OPHTHALMOLOGISTS ON STAFF AT THE SCHOOL.

# Pharmacology Training In Schools

## A Comparative Analysis Optometry, Medicine and Dentistry

Alex Waigandt, Ph.D. and Marti Waigandt, B.S.

### Introduction

As a profession under close scrutiny with regard to the use of pharmaceutical agents, it is necessary that optometry not only demonstrate that ocular agents have direct application to optometric practice, but that practitioners are qualified to use these agents. There is an abundance of literature which shows the clinical necessity for the use of ocular agents.<sup>1-4</sup> To date, however, there have been only two studies designed to analyze the training and, therefore, qualifications of optometry school graduates in the use of drugs relative to their practice.

Hegeman<sup>5</sup> compared the pharmacology courses for optometry and medical students at the University of Indiana and showed that the two professional programs utilized equivalent classroom hours in pharmacology training. Another study<sup>6</sup> conducted in 1984 at the University of Houston, which analyzed data collected from the pharmacology programs at 41 schools of optometry, medicine and dentistry, showed quite clearly that optometry students received as much training as medical school students and more training than dental school students. In fact, this study revealed that, with regard to the agents which have direct application to the general practice of optometry, these students received more than 30 times the classroom hours received by medical and dental students.

In light of these data, it is ironic that, in Texas, the licensed optometrist cannot utilize ocular pharmaceuticals in his or her office or prescribe any drugs relevant to the management of ocular health problems, while medical and dental school graduates are licensed to use any drug related to their practice. Is there any justification for denying the optometrist the same privilege? What unanswered questions might still cause doubt about the optometry

school graduate's qualifications in safely and effectively using ocular agents?

Since pharmacology as a discipline is an applied clinical science as well as a basic science, one possible weakness of previous pharmacology studies involving optometry was that possible variability in non-didactic pharmacology training among school types was not accounted for. **In order to relieve any criticism of the optometrist's qualifications, it is necessary to look at the complete pharmacology training package by analyzing the hours devoted to non-didactic pharmacology training in conjunction with classroom hours.** Therefore, the intent of this study is to provide a comprehensive review of pharmacology training in schools of optometry as compared to medical and dental schools. Although reported in a previous publication,<sup>7</sup> didactic hours will be reported with an analysis of non-didactic hours in order to present a total pharmacology learning package per school type.

### Procedures

The fourteen states which contain colleges of optometry (Alabama, California, Illinois, Indiana, Massachusetts, Michigan, Missouri, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, and Texas) were designated as study states. Data were collected from 83 randomly selected colleges which included optometry (N = 15), medicine (N = 37), and dentistry (N = 31). The department chairperson or director of pharmacology in each school was identified as the study respondent.

Since data regarding didactic pharmacology training hours had previously been collected, the research design proposed to combine these data with an analysis of data pertaining to the school types' non-didactic pharmacology training

hours. Therefore, respondents were directed to estimate how many non-didactic pharmacology training hours the student would receive during their four-year program. The study instrument defined non-didactic pharmacology training hours as "specific instruction in pharmacology and pharmacological procedures and should include laboratories, discussions, seminars, etc."

Results from the instrument were analyzed using SPSS\* and calculated on the AS9000 computer at the University of Houston. Treatment of the data was performed implementing means, standard deviations and analysis of variance (ANOVA). Additionally, the computer was programmed to calculate "post hoc" analysis on dependent variables whose F-ratio indicated significant differences. The .01 alpha level was selected for statistical significance.

### Analysis of the Data

Fifty-one of the 83 schools that were sent the instrument responded with usable data (61.4 percent response rate overall). Eleven were schools of optometry (73.3 percent response rate), 20 were schools of medicine (54.1 percent response rate), and 20 were schools of dentistry (64.5 percent response rate).

The results of the pharmacology study instrument in terms of mean responses and statistical comparisons between the study groups for both dependent variables are presented in Figure 1 and Table 1. Figure 1 illustrates overall didactic and non-didactic pharmacology training hours for students attending schools of optometry, medicine and dentistry. Table 1 presents means, standard deviations and analysis of variance of didactic and non-didactic pharmacology training hours for the school types.

The first dependent variable for

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*3-30-87*

comparison is total didactic (classroom) pharmacology training hours. The range of study hours for this variable is 88. One of the schools surveyed spends only 39 hours, whereas another spends 127. The grand mean for all school types is 85.05 hours. An analysis of variance indicates that significant differences exist among the school types for classroom hours spent teaching pharmacology ( $F = 15.46, p < .01$ ). Post hoc analysis (Scheffe' procedure) indicates that schools of dentistry require fewer classroom hours in pharmacology training than both optometry and medical schools, but that no differences exist between colleges of optometry and medicine.

Non-didactic pharmacology training hours is the second dependent variable for comparison. Figure 1 shows a graphic comparison for non-didactic pharmacology training hours for schools of optometry ( $\bar{X} = 27.81$ ), medicine ( $\bar{X} = 21.25$ ), and dentistry ( $\bar{X} = 16.75$ ). Data analysis is presented in Table 1. While optometry schools require approximately 27.81 non-didactic pharmacology training hours (optometry schools also have the greatest amount of variability [S.D. = 32.80] with a range of 100+ hours) which is 11.98 about the grand mean of 20.90 hours, medical schools require 21.25 hours and dental schools utilize approximately 16.75 hours. No significant differences, however, exist among the school types ( $F = 1.12, p = .33/n.s.$ ) for non-didactic pharmacology training hours.

### Conclusions

This survey presents some revealing quantitative information concerning the teaching of pharmacology in optometry, medical, and dental schools. As summarized in Figure 1, optometry requires significantly more total didactic pharmacology training hours than dentistry and an amount comparable to medicine. To complete the total pharmacology package students receive during their academic program, this survey queried

Figure 1. Didactic and Non-didactic Pharmacology Training Hours for Schools of Optometry, Medicine and Dentistry.

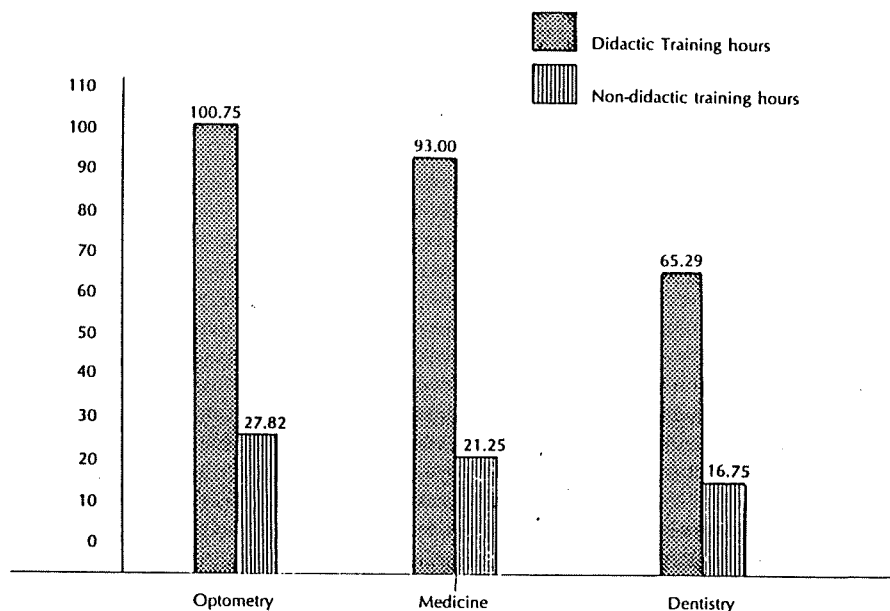


Table 1. Analysis of Variance of Didactic and Non-didactic Pharmacology Training Hours by Optometry, Medical and Dental Schools.

Dependent Variable	Independent Variable			Grand Mean (SD)	F-Ratio	F
	Optometry $\bar{X}$ (SD)	Medical $\bar{X}$ (SD)	Dental $\bar{X}$ (SD)			
Classroom (didactic) Lecture Hours	100.75 (14.24)	93.00 (15.47)	65.29 (19.40)	85.05 (16.71)	15.46	*
Non-didactic Training Hours	27.81 (32.88)	21.25 (18.05)	16.75 (9.50)	20.90 (19.79)	1.12	N.S.

\* $p > .01$

the number of non-didactic pharmacology training hours among schools of optometry, medicine, and dentistry.

Data collected regarding laboratories, discussions, seminars, etc., in pharmacology training showed no significant differences among the school types. This finding should dissolve any remaining controversy concerning the optometrist's qualifications for the use of pharmaceuticals in his practice.

With an evaluation of the total pharmacology training package completed, one can conclude that optometrists are at least as qualified to utilize pharmaceuticals in their practice as medical and dental practitioners who are licensed to use these

agents. Therefore, there is no justification for denying the optometrist the same privilege. There are a few states that allow optometrists to use drugs for diagnostic and therapeutic purposes; however, most states allow graduates of optometry schools to use drugs for diagnostic purposes only, and in Texas they are not allowed to use any drugs in their practice.

As health professionals, educators, and researchers, we must assume the responsibility of enlightening our colleagues in other health professions as to the credentials of the optometry school graduate. For the sake of the profession and the public, we must continue to deliver this message un-

Cont'd on Page 28

**PHARMACOLOGY TRAINING**  
*Cont'd from Page 27*

til optometrists nationwide are allowed to use the pharmaceuticals appropriate to the practice.

This project was funded, in part, by the University of Houston Urban Education Research Center.

*Reprinted with permission from TEXAS OPTOMETRY, December 1986.*

*Alex Waigandt, Ph.D., is an assistant professor at the University of Houston, visiting assistant professor at Rice University and a lecturer at Baylor College of Medicine.*

*Marti Waigandt, B.S., is a fourth-year optometry student at the University of Houston.*

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3. Jose, J.G.; Polse, K.A.; Holden, E.K.; *Optometric Pharmacology*. New York, Harcourt, Brace & Jovanovich, 1984, pp. 117-142.

4. Transcript of the Testimony of Dr. James F. Koetting "Urging support of H.B. 104 permitting optometrists to use topically pharmaceutical agents in the examination of the eye and the evaluation of vision" before the Subcommittee on Health, Committee on Pension, Social Welfare and Public Health, Mississippi House of Representatives, January 26, 1981.

5. Hegeman, S.: "Comparison of pharmacology courses for optometry and medical students." J. OPTOM. EDUC., 1983; 9(1): 22-23.

6. Waigandt, M.G.; Waigandt, C.A.: "An analysis of pharmacology training in schools of optometry, medicine and dentistry." J. OPTOM. EDUC., 1985; 10(3): 20-25.

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TRANSCRIPT OF MEETING BETWEEN  
KSOS EXECUTIVE BOARD AND KOA EXECUTIVE BOARD

September 22, 1986  
Capitol Building, Topeka, Kansas

Participants:

Senator Jack Walker, Chairman

Optometrists

Dr. Pete Brungardt  
Dr. David Crum  
Dr. Larry Harris  
Dr. Terry Hawkes

Ophthalmologists

Dr. Frank Griffith  
Dr. Delores Bell  
Dr. Perry Schuetz

Senator Walker's Opening Comments:

Both groups are held in high regard. I think the Committee feels that in general this is a turf battle--that's an honest appraisal. Most of the time when we have these groups, the Committee has a tendency to think "well, you know there's a lot of biased turf". The bottom line under that is probably money. And the question of quality kind of gets down the road in the eyes of the Committee. I think that the other thing I felt was that if there was a sentiment, it probably was a little more sentiment on the part of the Committee for the optometrists. I think that I don't know what would have happened had the Bill come out of Committee. Of course, it has a long way to go. It has to go to the House. Then it has to go to the full legislation and so I don't know what would have happened. I had a feeling that if we would have forced a vote last year that probably the optometrists would have won. Even though I made it clear from the very beginning with the optometrists that I'd have to vote with the other side--and they knew that. Looking to next Session, there's a possibility I won't be there. I hope. I don't know who will be there in my place. But it probably won't be a physician or an optometrist. Unless Hawkes wants to run. (laughter).

After all that background, it seemed to me sitting there and listening as a physician that I understood both sides of the problem. I understand the need for quality. I don't think anybody would question the fact that care of the eyes is extremely important and a delicate area of health care. And we certainly have to have all the quality control that we can possibly have; this does mean proper preparation in educational background and training. But as I also listened, I thought that some of the things that were being proposed were not terribly unreasonable. I and the family physicians use drugs in treatment of eyes and were not very well trained. I can tell you that. Running a

~~Attm 2~~  
3-30-87

training program, my residents get a smattering of eye training; we wish we could get more but there are two problems. One is just finding people who are willing to take residents and be bothered with them, as it's a time consuming chore for very little reward. Secondly, just finding time in the curriculum when family doctors have to do a lot of other things during their three years training. We get some training; we send them a month with A. L. Lemoine and listen to his lectures. And they're excellent lectures. We see some patients in our clinic with eye problems. We have some experience in the Emergency Rooms. They do moonlighting where they probably learn more there than anyplace else. When they moonlight, they run up against eye problems, but I don't know how well they are supervised at that time in the Emergency Room. But basically, I would say we're not very well trained in the primary care of the eye. I know that we use drugs, we use antibiotics, we use steroids. Family doctors remove surface foreign bodies and by and large, I've felt that they don't get into too much trouble--you may take exception to that.

So I felt that there was about four areas in this thing. And I want to tell you that the optometrists came to me this time last year with their Bill. Dr. Hawks came to my office, and it was an outrageous Bill to start with. I said "you guys haven't got a chance in hell of getting anything like that through, because the ophthalmologists will rise up in force". So we went back. I said "take it back and work it out again and bring it back. See if you can bring a more reasonable thing in" and I think we did it even a third time. We looked at it a second time and said "you know, I still think there's one or two areas in here which are going to cause problems". So they took it back and looked at it even a third time before I decided they might have something reasonable for the Committee to look at. I thought there was about three or four areas, certainly antibiotics was one of them. I guess at the top, though, was what I would call quality and educational prerequisites or training that was overriding everything that everybody was interested in to ensure that the people who were doing it had had the proper experience or would get the proper experience.

Antibiotics, steroids, surface foreign bodies--that got into the very emotional area of surgery. I thought that maybe we could define what really is surgery and probably what isn't surgery. I don't know, I think to me were the three areas that were debateable and caused a lot of the emotions was these three areas. I just felt and the Committee felt that maybe these two groups could sit down and look at these areas: the education, antibiotics, steroids, and possibly removal of surface foreign bodies compared to what I would call surgery. We're not talking about laser surgery in the wildest dreams. I'm sure we're not talking about that. We can clarify that and get that off the table. We're talking about surface foreign bodies and we do not consider that to be surgery in the normal context. Every-

thing else is surgery with the eye as far as I'm concerned. Oh, I know the other one--glaucoma. I think that at least in my discussions with both groups, my mind is perfectly clear on glaucoma; I don't



think the optometrists ought to be primarily responsible for glaucoma. I would hope because of the convenience for patients, that there might be a working relationship to work together on this, because sometimes you do have patients out in the hinterlands that need to be seen periodically to have their pressure tested, drugs renewed, and maybe that's inconvenient to go to the city and see the ophthalmologist. I don't know whether some kind of a working consultative relationship, most of you already have that, you work with each other where an initial suspected glaucoma problem would always be seen in consultation initially. We do that in our training family doctors. We tell them that this is a problem that should always have consultation. And maybe referral. It depends on the severity or if you have a close working relationship. I mean by the telephone or where the patient is seen by the ophthalmologist. Maybe that kind of relationship could be worked out for glaucoma. I don't think there's any misunderstanding that the management of glaucoma is a very serious problem and should be in the hands of an ophthalmologist. So I'd add glaucoma, as far as I know, those were the areas outside of pure emotions that everybody got pretty heated. This is where I stop ladies and gentlemen. I think that what the Committee would like to see is that you all reach a compromise understanding and agreement and be able to bring it back to that Committee, and be able to say that "we've reached this agreement, we understand each other". These are the things that need to be done in a Bill to permit these things to happen, and you all get back together and continue to work together. That's what we would like to see. If we can't, I suppose you can let it fly any way you want to; let it fly next spring. The optometrists can introduce their Bill and I think the Committee will say okay. Let her go and see what happens.

I did get a letter from Ron Hein saying there was some concern about a new Bill: As far as I'm concerned, I'm dealing with the Bill we had last year. Unless the optometrists, Terry, are writing a new Bill that I don't know about.

Terry Hawkes:

We're not writing a new Bill because we're in negotiation regarding this Bill.

Senator Walker:

As far as I'm concerned we're dealing with the same points we were last April with nothing hidden in the wings. I think we should remove that right away. They have no new Bill that I've seen or heard of.

Pete Brungardt:

We have thoughts, but we don't have a Bill.

It's far more predictable than what a P.A.M. is as far as determining whether that patient with a cataract should go over for cataract surgery in making that referral. Why should we send him through a \$300 cataract work-up, which is what charges here in town, if we know the guy has a bad retina.

Peter Brungardt:

Larry, you're wearing me out. Let's you know---

Senator Walker:

Let me just say one thing after listening to this for 45 minutes. There's a lot of discussion about what went on 15 years ago and when we all went to medical school. The only thing I can tell you is that as one who's about ready to quit, medicine is undergoing a tremendous revolution. I don't know what the outcome will be. I'm very concerned about what's going on in medicine in terms of corporate practice of medicine. And we seem to be moving away from all the things we learned in school. I don't know what it's going to be like 10 years from now down the road. We've been through 20 years of manpower changes. In family medicine, we dealt with the same problem that you're all talking about. The nurse practitioners came along; out of the war came the physician assistants; now we've got emergency room techs and pharmacy techs that prescribe drugs. And most of us didn't like that and saw it as a threat and questioned the quality. But we were overridden by politics, the public. But we live with them now. There are nurse practitioners that do things we used to do and I have to admit, they probably do them just as well as we did. There's always the threat that they will want to do more. They're always there, they want to do more, but we did live through the changes in the sixties with the new group of health manpower people that are doing things 15 years ago we would have said "no way can you do these things". The world is changing in health care delivery. My concern, rather than you two fussing about how you're going to step on each others' toes. It seems to me like this is two groups that has a very mutual ability to work together. As I look at ophthalmology, I don't know any field that has made greater advances in the last 20 years than the care of the eye. You can do things today that we never dreamed of. You used to take cataracts and they were in the hospital for 7 days with their hands tied down. Today they go home in 12 hours. All the instrumentation that's available in ophthalmology overwhelms me. So it seems to me, that the ophthalmologists are going to be moving into another world almost, another level of responsibility and care. I guess, I don't see, it seems to be relatively logical that this group (the optometrists) is probably going to move up a little in their delivery of health care when you people move off into the exotics. I don't know what's going to be done in ophthalmology in the next 10 years. Probably eye transplants or something. It looks like to me. (NOTE: The rest of Senator Walker's comments were not recorded as tapes were switched).



# KANSAS MEDICAL SOCIETY

1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

March 30, 1987

TO: House Public Health and Welfare Committee

FROM: Jerry Slaughter *J. Slaughter*  
Executive Director

SUBJECT: SB 113; Concerning Optometric Scope of Practice

We appreciate the opportunity to comment on SB 113, which would allow optometrists to utilize certain drugs for therapeutic purposes, and to remove foreign objects from the eyes. The Kansas Medical Society represents 3,500 doctors of medicine, in all medical specialties, widely distributed in every county of our state. We are strongly opposed to this legislation.

It is our belief that the legislature should enforce a very high standard on those who wish to prescribe drugs, especially as it relates to care of the eyes. Optometrists are asking you to grant them the authority to treat patients medically with absolutely no patient care link to a physician. There is nothing in the bill that would require an optometrist to seek medical consultation for patients with serious eye disease.

Primary care physicians currently provide our citizens with excellent eye care for "routine" medical eye problems, and refer serious matters to ophthalmologic specialists. The system works well, and the public is assured of competent practitioners providing medical eye care. In fact, we are unable to detect any public outcry for this legislation.

Is the current structure inadequate? Is the care rendered by primary care physicians and eye specialists not getting the job done? Are people in rural and urban areas asking you to lower the requirements for those who wish to prescribe drugs and practice medicine in their communities? We think not.

In fact, if you pass this legislation, in essence you are saying that someone with less training than a physician is fully capable of treating eye disease. If that is true, why require physicians to go through a rigorous, 7-8 years of medical school and clinical residency training? At a time when our citizens, and our courts, are demanding more accountability and higher standards of care, is this proposal a step forward or backward?

*P. H. W.*

*Attm. 3*

*3-30-87*

We have been down this road before. Some years ago, optometrists wanted diagnostic drugs in order to more effectively serve their patients. Now it is drugs for therapy and removal of foreign objects. The original proposal last year included the authority to perform surgery. Where will their demands end? If you grant them their request this year, how can you refuse their desire to expand their practices in the future?

At what point, if we are to continue to have state regulation of health professionals, do we say no to those who want to broaden their privileges? Should legislators continually be asked to grant degrees through legislation, or do we leave that to our educational institutions?

If optometrists wanted to practice medicine, why didn't they seek a medical education? Aren't you being asked to make optometry school a shortcut to a license to practice medicine? If so, why not end the duplicity, and lower the educational requirements for physicians. I doubt that concept would garner much support up here, or among the public at large.

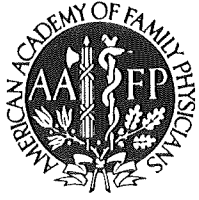
There are a host of limited license health professionals out there who want a bigger piece of the health care pie. I presume they all went into their particular disciplines with open eyes and realistic expectations of the professional role they would fill in the health care system. Doesn't anyone want to be what they were trained to be anymore? Each time the legislature grants a broader scope of practice to another group in this manner, it fuels the fire even more, and the requests multiply. Our health care system is the best in the world because it has a regulatory structure that assures quality by enforcing strict standards at each level up the pyramid. When the standards and distinctions among health professionals are blurred or relaxed, the structure will break down and quality will suffer.

In the long view that is the decision you face. Your action on this bill will send a message to every other group waiting in the wings, that to practice medicine in Kansas, a couple of weekend courses are all that is needed.

Is a rigorous medical education too much training? Are physicians over qualified to provide "routine" health care if everyone else can with lesser training? These are questions that only the legislature can answer.

We urge you to report SB 113 adversely. Thank you for the opportunity to appear and register our opposition to this legislation.

JS:nb



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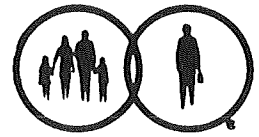
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## Kansas Academy of Family Physicians

818 Carriage Parkway, P.O. Box 20597 • Wichita, Kansas 67208 • (316) 651-2238



March 30, 1987

Mr. Chairman and members of the Committee: **Walter D. Bettis**  
*Executive Director*

My name is Art Snow. I am a practicing family physician in Shawnee Mission, Kansas. I received my M.D. degree from the University of Kansas in 1975. I did my residency training in Family Practice at KU, finishing in 1978.

I am also your Doctor-for-a Day today, so if I can be of any service to you or your staff, please let me know through the operator or my office outside the Senate gallery room.

I come to speak to you today as President of the Kansas Academy of Family Physicians regarding SB-113, an act concerning optometrists. As you know, the optometrists want to perform diagnosis and prescribe medications to treat eye disease. Rather than attend medical school to attain this right, they are asking the legislature to simply give this privilege to them. I feel the real issue is the quality of eye care for the patients of the State of Kansas.

There are approximately 80 ophthalmologists in Kansas. There are 300 optometrists and 730 family physicians across Kansas. There are an additional 126 residents in family practice training programs and 239 medical students who are student members of the Kansas Academy of Family Physicians, a great majority of whom we feel will be providing medical care in the State of Kansas.

We in family practice feel strongly that family physicians are very adequately trained in all areas of medicine, including the care of eye problems. Our training includes four years of medical school after four years of college and three years of postgraduate training to specifically train in family practice. This 11-year training program is opposed to the six-year training program of optometrists, which does not include training in the eye care of ill patients.

MORE

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"Representing the Largest Medical Specialty Group in Kansas"

Multiple systemic diseases and severe diseases of the eye can present as seemingly minor problems initially. Gonorrhea, tuberculosis, herpes infections, chickenpox, German measles, infectious mononucleosis, mumps, measles, fungal infections, histoplasmosis, toxoplasmosis, syphilis, systemic granulomatous disease, and sarcoidosis are all diseases requiring a full medical history and physical examination to diagnose and treat. All of these can present as eye diseases. Giant cell arteritis can be manifested by eye findings and can result in total permanent blindness, yet can present only minor eye complaints initially. These are all diseases that require comprehensive medical knowledge to diagnose and treat. In the best medical care, these patients can not be treated by a limited practitioner.

Medications placed in the eye can and do provide relief from the diagnosed condition, but can and do lead to other undesired and potentially dangerous side effects. These additional problems do not affect only the eye. Complete medical training is necessary to adequately diagnosis and prescribe for treatment of eye diseases and for treatment of the complications of these untoward effects. There can be untoward cardiac effects and even a complete shutting-down of the blood-producing organ of the body from the use of medication in the eye. Limited practitioners do not have the proper knowledge or clinical training to diagnose, or even be aware of these far reaching problems.

The Board of Directors of the Kansas Academy of Family Physicians feel strongly there is no need to offer to the residents of the State of Kansas anything less than the best in eye care (or any other medical care for that matter). Let's leave medical treatment to physicians.

Family physicians are: 1) available throughout the state, and 2) are appropriately trained in all aspect of medical care, diagnostics, and therapeutics, and are in the best position to deliver quality primary care to the eye.

We feel the family physician should remain the primary provider of quality care, with the backup of the ophthalmologists of the state when the physician requires additional assistance in this care.

Please do not lessen the quality of eye care for the residents of the State of Kansas.

Thank you,

Arthur D. Snow, Jr., M.D.  
Shawnee Mission  
D. Ray Cook, M.D., President-elect  
Wichita  
Richard Rajewski, M.D., Vice-President  
Hays  
Deborah Haynes, M.D., Secretary  
Wichita

Larry Anderson, M.D.  
Wellington  
Ken Wedel, M.D.  
Minneapolis  
Don Goering, M.D.  
Coldwater  
Tell Copening, M.D.  
Iola  
Tom Simpson, M.D.  
Sterling

March 31, 1987

House Public Health and Welfare Committee  
State Capitol  
Topeka, KS 66612

Re: Senate Bill 113

Mr. Chairman, Members of the Committee, ladies and gentlemen,

My name is Perry Schuetz. I am a medical doctor from Great Bend specializing in Ophthalmology. Also, I am the president of the Kansas State Ophthalmological Society. My society strongly opposes Senate Bill 113. I only wish that sufficient time was available to the legislature to fully discuss this very important issue, instead of the abbreviated testimony being offered today. This bill will be very dangerous for the eyes of all Kansans. The public welfare will be jeopardized. Some suggestions have been made to amend the bill, such as the removal of glaucoma therapy, but this only mitigates some of the inherent danger.

My society opposes the methodology of offering a five weekend course to paramedical personnel, whomever they may be, then state after a short didactic course that they should be certified to treat the public. Using this same methodology it would be conceivable to offer a five weekend course to opticians or physicians assistants and teach them the scope of traditional optometry--the fitting of glasses and contact lenses. Would this legislature then stand ready to certify these groups to an expanded scope of practice which would then include optometry? I think not. My society opposes the basic professional cowardice typified by the notion that since the grass is greener on the other side of the street, we will have the legislature grant us an ophthalmology degree instead of going to established institutions and established educational programs to earn this degree. My society opposes the hypocrisy of telling the public that an equal standard of care is rendered by these vastly different professions.

The legislature is besieged by all sorts of paramedical people wanting to expand their scope of practice. Allowing one group to do so and being consistent, the legislature sends the message to all others that now is the time to expand. Everyone wants to be a doctor, but only a few want to go to medical school. The rest seem to want the legislature to legislate a degree. Many these days enter into a profession and then seem dissatisfied with what they have become. Instead of having the courage to go through the training which permits them to do what they wish, they prefer to have the legislature redefine their profession.

In my short ten year professional lifetime optometry has tripled the mass of information for which they profess competency. Ten years ago they were fitting

glasses and contact lenses. Shortly thereafter they were certified competent to diagnose; this change doubled if not tripled the previous body of information to which they professed competency. Likewise, the therapy of eye disease again doubles if not triples the body of information of ten years ago. Yet, the optometry training programs are no longer now than they were then. All sorts of learning experiences are having to be contrived in order to attempt to bring optometry students in contact with diseased eyes simply because most people with any serious problem of their eye seek the council and treatment of a medical doctor and a medical institution, not an optometry school. Ask yourself where you would go if you were faced with a blinding disease.

Thirteen states now have optometric therapeutic drug bills, but only two of these states have an optometry school within their borders. What happened in the other thirteen states with optometry schools? Maybe, as in Pennsylvania, the legislatures have felt the optometrists were not qualified to use therapeutic drugs. Maybe they have seen Iowa, where optometrists are back to the legislature for the second time in two years, wanting more drugs.

The Kansas State Ophthalmological Society does not support any compromise relating to this legislation. The amendments offered to this legislation have been done by concerned legislators wishing to protect the public. As more items of this legislation disappear the public becomes more protected. Legislation expanding optometry into therapy is merely the first step in a legislative journey: all topical medications, oral medications, narcotics, minor office surgery, laser surgery, and then all surgery will follow. The legislature can certify optometry to do whatever it wishes; however, ophthalmology does not support or compromise with this legislation. If this bill passes, it should be required that it be hung on each optometrist's wall in lieu of the appropriate diplomas which are missing. Thank you.

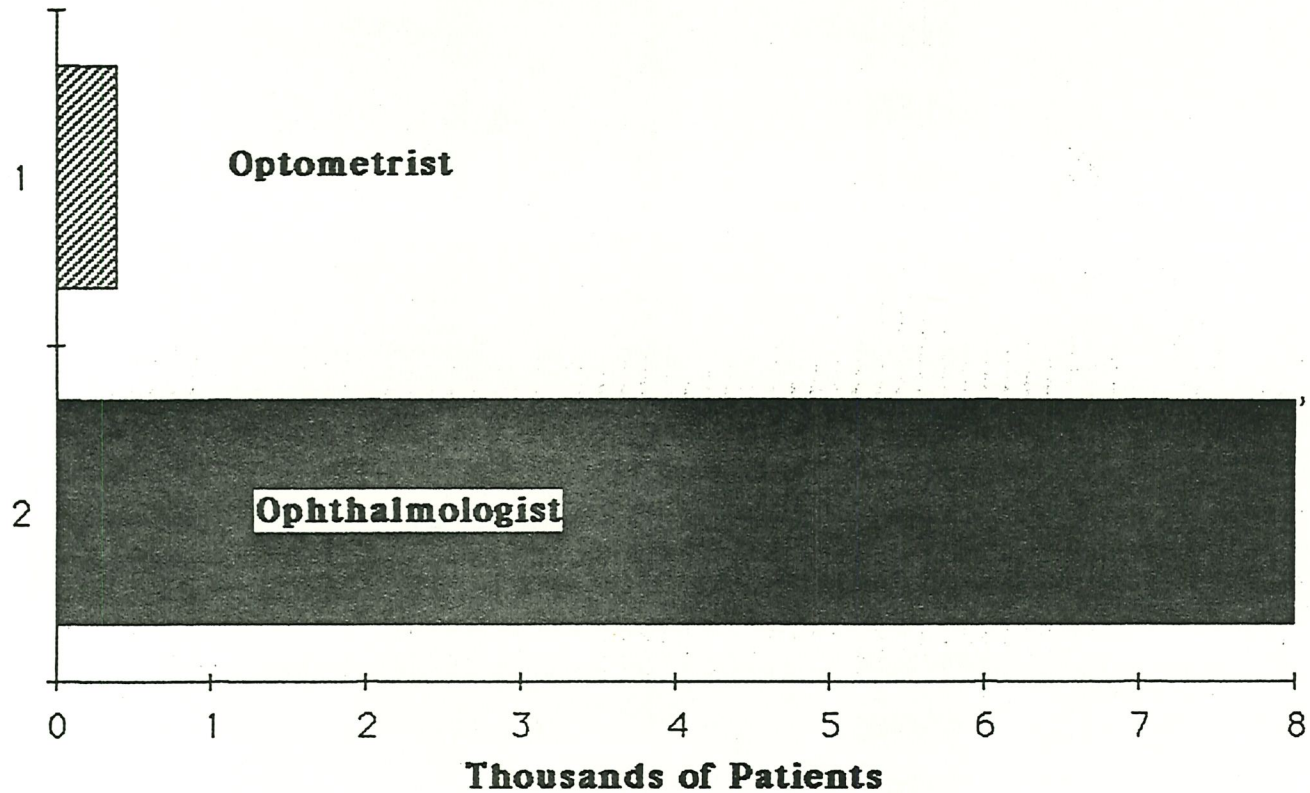


Addendum to the testimony of Perry N. Schuetz, M.D.:

The Pennsylvania House of Representatives Committee on Consumer Affairs, comprised of 24 members, was assigned responsibility for reviewing and evaluating the State Board of Optometry Examiners. During 1985, the Committee conducted four public hearings on six separate days in the cities of Harrisburg, Philadelphia, and Pittsburgh. Two days of hearings were held at the Wills Eye Hospital in Philadelphia, and members of the Committee toured the Pennsylvania College of Optometry in Philadelphia, too. The Committee on Consumer Affairs heard considerable testimony concerning a proposed change in the scope of practice of optometry to include treatment of eye diseases. The Committee then made the following points in its report to the legislature:

"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 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 an authorization would not have an adverse impact upon the health and safety of eye care patients in Pennsylvania."

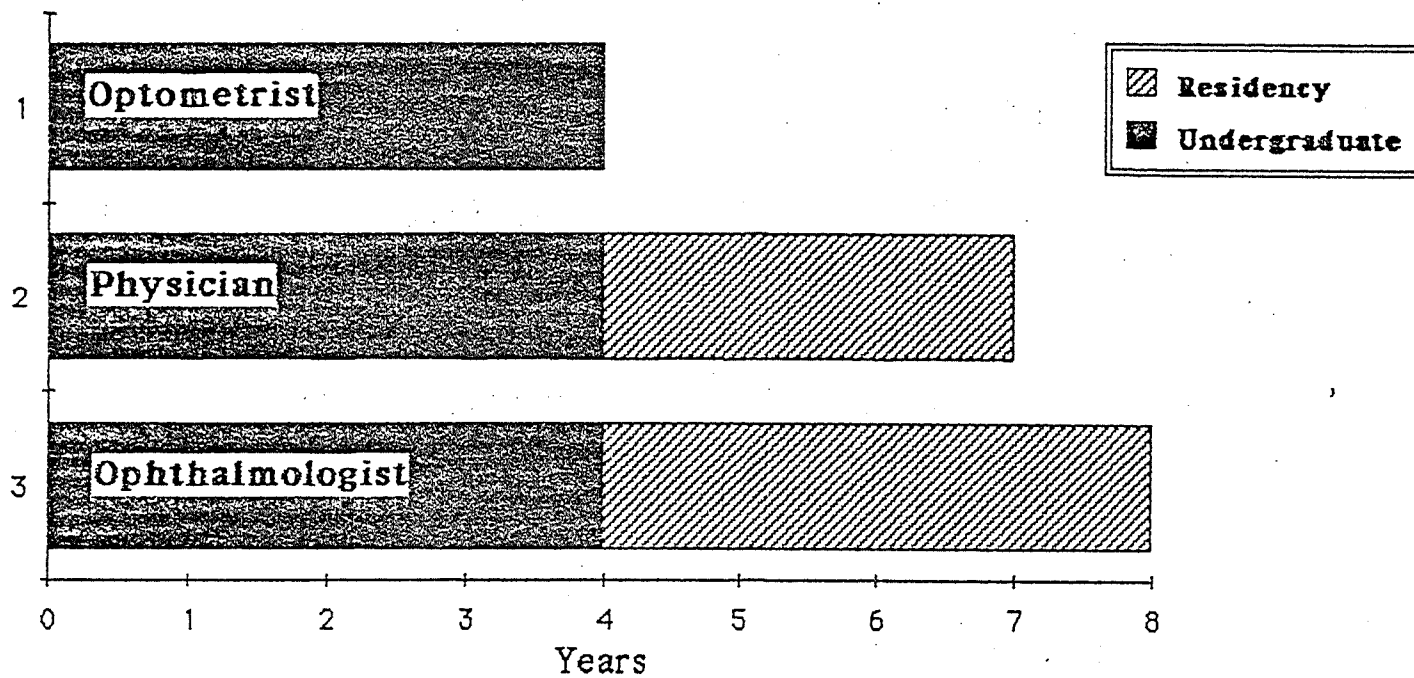
# Patients Treated in Training



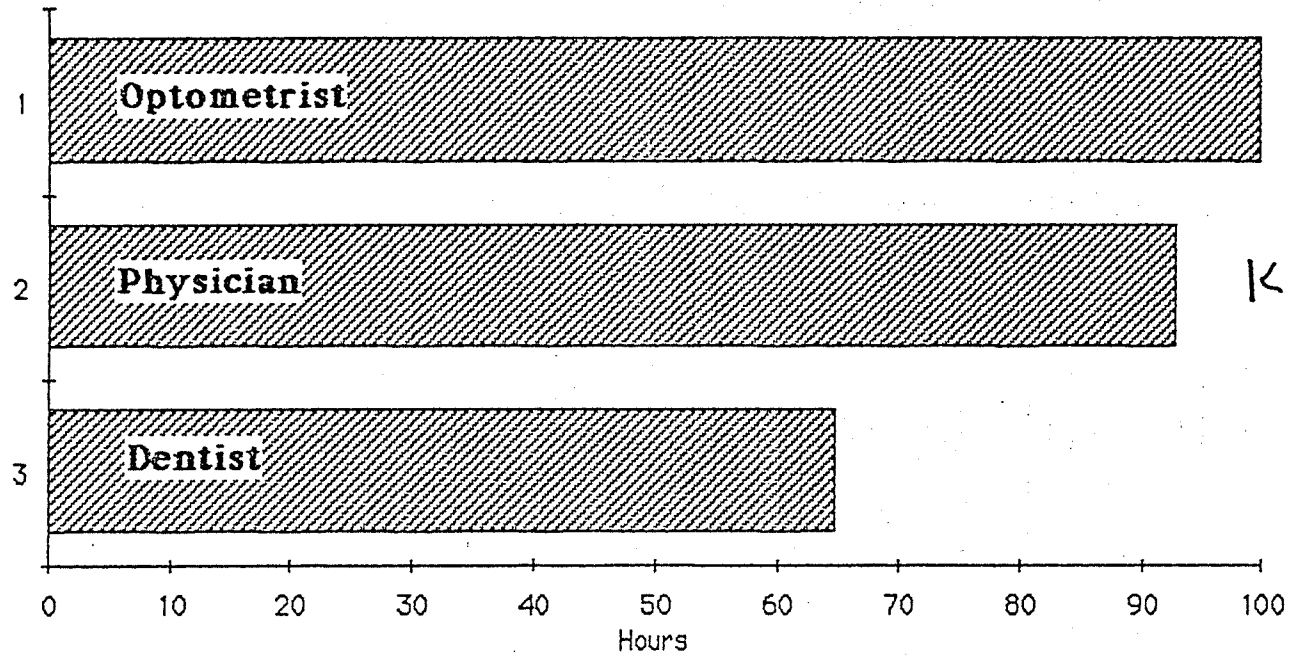
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# Professional Education

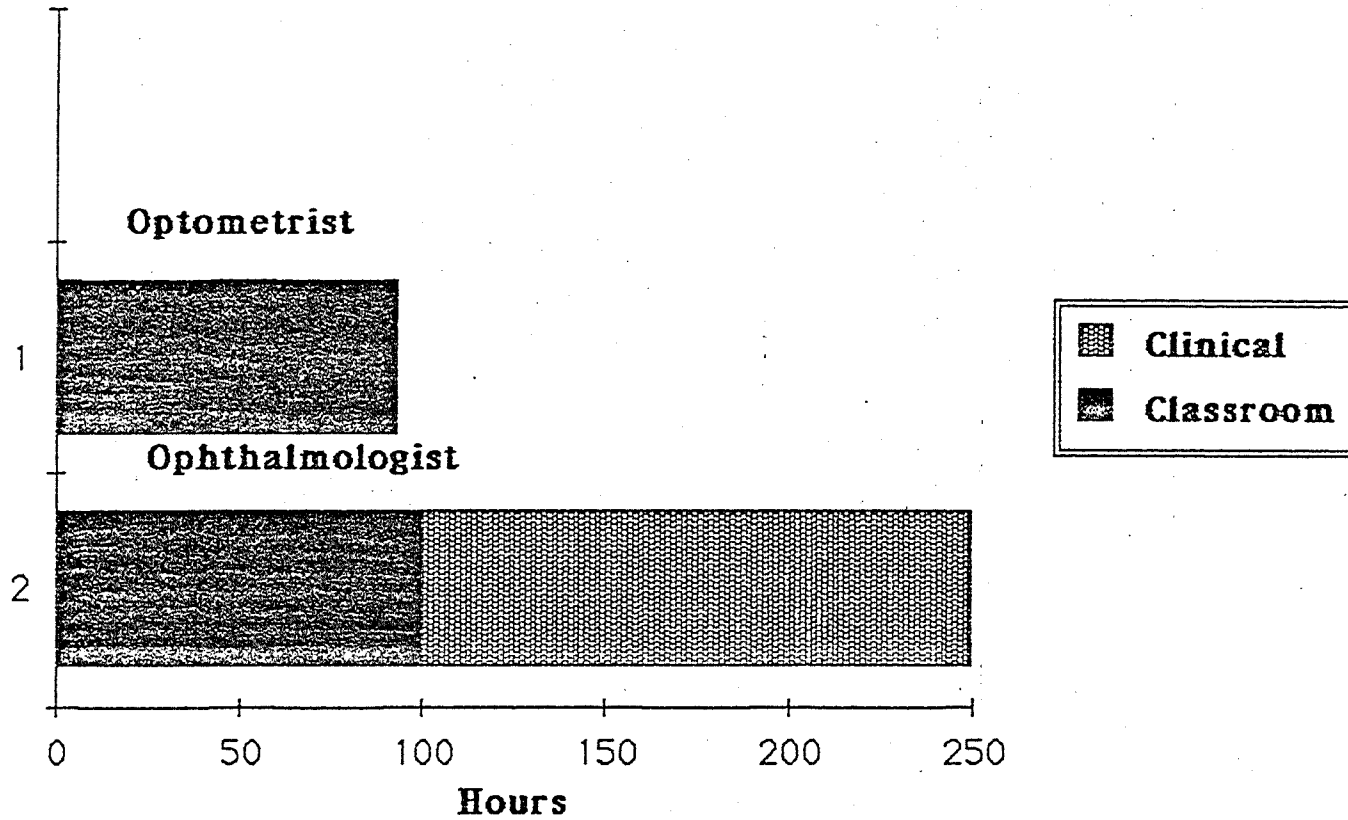


# Hours of Classroom Pharmacology



KU 174 hours

# Pharmacology Education





March 27, 1987

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House Committee on Public Health & Welfare  
House of Representatives  
Kansas State Legislature  
Topeka, Kansas 66612

Dear Representatives:

I am writing in opposition of Senate Bill No. 113 and urge you to vote against the proposed legislation. This bill would unnecessarily increase our group medical insurance costs by requiring our group medical plan to reimburse optometrists when treating an illness or injury. Our group insurance plan is designed to cover the services of a physician when diagnosing and treating illnesses or injuries. This unwarranted increase in cost would occur during a time when Beech is undertaking extensive product development and attempting to control expense.

It is our desire for our employees and their families to receive the highest quality care when confronted with illness or injury. This legislation would restrict or delay their referral to qualified physicians or ophthalmologists. We see no reason for this. We believe that it is in the best interest for injured persons to have immediate access to a healing arts practitioner; efforts to preserve eyesight is certainly no exception.

Sincerely,

  
Richard R. Griffiths  
Vice President, Industrial Relations

RRG:ij

RRG  
Attm #7  
3-30-87

TESTIMONY BEFORE

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE  
S.B. 113 - DEFINING PRACTICE OF OPTOMETRY

Presented By: Boeing Military Airplane Company  
Ron Gaches, Public Affairs Manager

Senate Bill 113 concerns the practice of optometry. One of its features permits the administering, or dispensing, of topical pharmaceutical drugs by a licensed optometrist.

The Boeing Military Airplane Company is not opposed to enactment of this legislation. We recognize that adding such authority may provide some cost effective benefits to the recipients of such medical treatment. We believe that professional medical testimony should determine the authorities of licensed medical providers.

Thank you for your consideration of our position.

*PAW*  
*Attn # 8*  
*3-30-87*