

Approved 2-17-87
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

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

10:00 a.m./~~pm~~ on February 11, 1987 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Legislative Research

Conferees appearing before the committee:

Gary Robbins, Executive Director, Kansas Optometric Association

Peter Brungardt, O.D., Salina, Kansas

Lesley L. Walls, O.D., M.D., Glenpool, Oklahoma, written testimony only

Thomas Lewis, O.D., Dean of Academic Affairs, Pennsylvania College of
Optometry

Bill Crawford, O.D., Chief of Optometry, Wyandotte/Johnson County and South
KC Region of Prime Health HMO

Greg Besler, O.D., Topeka, Kansas

Others attending: see attached list

SB-113 - An Act concerning the optometry law; defining the practice of
optometry; establishing continuing education requirements;

Gary Robbins introduced the four conferees to the committee, and presented
testimony from the Kansas Optometric Association. (attachment 6)

Pete Brungardt, O.D., testified and presented written testimony on SB-113.

Dr. Brungardt stated that the optometrists were asking to use medications on
the eye to treat conditions limited to the eye. Currently they are diag-
nosing these problems and referring them to various medical specialties for
treatment. (attachment 1)

Written testimony by Lesley L. Walls, O.D., M.D. was referred to by Dr.
Brungardt in his testimony. Dr. Wall stated that few medical students choose
ophthalmology as a clinical rotation and therefore have very little exposure
to that area of clinic experience. Dr. Walls stated that he was in support
of optometrists being permitted to use pharmaceutical agents. It was his
opinion that the key to utilizing medications by any health care professional
is proper education and training. (attachment 2)

Senator Hayden's pages, Sibyl Ives and Holly Russell from Satanta and Derek
Stevens from Sublette were recognized.

Thomas Lewis, O.D., testified and presented written testimony on SB-113.
Dr. Lewis reviewed his credentials for the committee and discussed some of the
basic elements of optometric education as they relate to the legislation
being considered by the committee. It was stated that the number of hours
of pharmacology presented are equal to or greater than all other health
professions that use therapeutic pharmaceutical agents exclusive of resi-
dencies. Dr. Lewis stated that there is constant comparison between
optometry and ophthalmology. The comparison should be made between optometry,
dentistry, podiatry and general medicine. Optometrists simply want to
practice their profession to the limit of their competencies. (attachment 3)

Bill Crawford, O.D., testified and presented written testimony. Dr. Crawford
testified that he has, for sometime, been practicing in an HMO setting in the
Wyandotte/Johnson County and south KC Region of the Prime Health HMO. In
this situation he is legally allowed to use the pharmaceuticals for $\frac{1}{2}$ of his
work week, which Kansas is now asking permission to use. It was further
stated that the reasons for passage of this bill could be broken down into

Unless specifically noted, the individual remarks recorded herein have not
been transcribed verbatim. Individual remarks as reported herein have not
been submitted to the individuals appearing before the committee for
editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

room 526-S, Statehouse, at 10:00 a.m./~~p.m.~~ on February 11, 1987

three main areas: (a) increased quality of Kansas primary eye care (2) increased accessibility for all Kansas residents to good quality eye care (3) decreased costs to Kansans seeking primary eye care. (attachment 4)

Greg Besler, O.D., testified and presented written testimony on SB-113. Dr. Besler reviewed his education for the committee, also the externship served. He stated that (a) clinical training of current optometry students is supervised by optometrists and physicians; (2) optometrists and optometry students are successfully treating eye disease across the US in federal institutions as well as states where therapeutic drug laws have passed; (3) we can perform these services as students but not as doctors; (4) we are losing new O.D.s to the other states because they are not allowed to utilize their full training in Kansas. Some of these students are ones that the state of Kansas has invested money in by virtue of a state contract. (attachment 5)

Senator Bond announced that the subcommittee on SB-33, SB-34 and SB-35 would meet Monday, February 16 at 10:00 a.m. in room 526-S.

Senator Salisbury announced that the subcommittee on SB-78 will be held Friday, February 13, 1987, at 8 a.m. in room 531-N.

The meeting adjourned at 11:03 a.m. The committee will meet Thursday, February 12, 1987, at 10:00 a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-11-87

(PLEASE PRINT)
NAME AND ADDRESS

ORGANIZATION

Harold Riem	Ks. Assn Otolaryngic Med
J. Beard	Optometrist
Darryl Ann	OPTOMETRIST
William Crawford	Optometrist
Thomas Lewis	Optometrist
Jay Hawks	KOA
LARRY LUTTJOHANN	KOA
Jane A. Summers	Optometrist
GREG BESLER	OPTOMETRIST (KOA)
Gary Robbins	Ks Optometric Assn
Pete Brungardt	"
GREG Joyce	"
Bill Henny	Ks Optometric Assn
Howard Sedgwick	KCOA
Helen Sedgwick	KCOA
Iva Arndt	KCOA
Willard Jantz	KCOA
Jacque Oakes	KACD
Jim Yonally	KOA

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Feb 11, 1987

(PLEASE PRINT)
NAME AND ADDRESS

ORGANIZATION

HAROLD C. Patis

KCOA

Dec Bell

Kansas (Ophthalmology) Med Soc.

Frank Griffith

Kansas Ophthalmology Society

Albert N Lemoine, Jr

" " "

Perry N. Schuetz

" "

John Peterson

Ks Opticians Assn

Belva Ott

Planned Parenthood of Ks.

~~Jerome S. Schaefer~~

KS MEDICAL SOCIETY

W D Buehlman MD

Ks Medical Soc. President

Rebecca Crenshaw

KSOS

Ron Hein

KSOS

Larry E Harris

Ks Optometric Assn

Don Mitchell

VISTOR

Ken Schafermeyer

Ks Pharmacists Assoc

TESTIMONY

SENATE PUBLIC HEALTH & WELFARE COMMITTEE

FEBRUARY 11, 1987

I am Peter Brungardt, a practicing optometrist from Salina. I was graduated from the Pennsylvania College of Optometry in 1971. I am currently president of the Kansas Optometric Association. It is my pleasure to represent 300 Kansas optometrists. The KOA represents 95% of the optometrists in Kansas.

The issue before the committee today concerns the proposed use of topical therapeutic drugs and non-surgical foreign body removal by optometrists. Last session, this committee held hearings on the same question, but did not take action on the bill. The committee did encourage optometry to meet with ophthalmology for discussions which might produce an acceptable compromise. During negotiations, optometry presented proposals consistent with SB 651 of last year, with the addition of a prohibition on surgical acts; and we also limited the scope of glaucoma treatment. Ophthalmology countered with the suggested use of topical antihistamines and topical decongestants (such as Visine). Both of these are commonly found in over-the-counter medications at present. In other words, ophthalmology was not open to discussion of change. Much time was spent discussing ophthalmology's concern about optometric education. Ophthalmology suggested training at KU School of Medicine. We explored this possibility with the Chairman of Ophthalmology

SPH/W
2-11-87
Attachment 1

at KU. He declined any involvement with optometry as he has done in the past. In fact, ophthalmology wished only to delay, not negotiate, and they succeeded in delaying this action.

Since the hearings of one year ago, five additional states have passed similar measures to SB 113, bringing the total to twelve. The plain states of Oklahoma, Missouri, Iowa, Nebraska and South Dakota are among those states with therapeutic legislation. North Carolina and West Virginia have had similar laws for ten years.

The basic concept of this proposal is quite simple. We are asking to use medications placed on the eye to treat conditions limited to the eye. We are currently diagnosing these problems and referring them to various medical specialties for treatment. This practice is unnecessary, inefficient, costly, wasteful and unfair to both optometrists and their patients.

Accordingly, let us discuss the reasons for this bill.

Optometrists are generalists with doctorate degrees in eye and vision care. We are the eye doctors for the majority of Kansas citizens.

We are well versed in basic science and the applied disciplines of anatomy, physiology, pharmacology -- as concerns both general body and eye. Please refer to your handout on the comparisons between optometry, dentistry and medical school. While direct comparisons are difficult, optometrists compare favorably with other disciplines. Optometric students train in various clinical settings, designed to allow those in training

ample opportunity to diagnose and treat a broad range of visual and eye problems. The Kansas Optometrists currently in practice have an extensive base of clinical experience in disease detection and the resolutions of those problems as they refer and follow their patients. Last fall, over 190 optometrists completed a six credit hour graduate level course in ocular therapeutics. This one hundred hour classroom and clinic education has been used in several states where optometrists are currently using ocular therapeutic agents. This spring, 20 sub-specialty trained Kansas Ophthalmologists will present a clinical course to those same optometrists. As a further protection, the State Board of Examiners in Optometry will examine and specifically license qualified individuals who demonstrate their abilities by examination. You will be told that this doesn't equate to ophthalmological training. We don't want to the ophthalmologists. Primary care physicians treat these problems with significantly less training in eye disease than optometrists. That is the standard of care.

Knowledge does not belong exclusively to medicine or anyone else. Optometrists are well-trained and educated. We are taught by scientists, PhD's, optometrists and physicians. Our schools are respected and accredited. Medicine routinely uses new techniques and medications as their knowledge expands. Generally, this improves patient care. Optometry is simply coming to the legislature to change our limited licensure to reflect current realities. This question should concern medicine not at all. Their only interest involves their

exclusive domain granted by law.

Since 1977, optometrists have used pharmaceuticals for diagnostic purposes. While many of these agents have potentially dangerous side effects, the decade of use has produced only benefits to the Kansas citizens. You will hear much made of the dangers inherent in the application of drugs to the human body. It should be noted that the drugs already commonly used by OD's have the possibility of harming patients. It is worth remembering that Kansas ophthalmologists testified in 1977 that patients would be harmed with these drugs.

Why aren't people hurt in the states with diagnostic or therapeutic legislation? The reasons are not hard to understand.

First, OD's understand the potential dangers and can eliminate pre-existing risks and associated conditions with a thorough history.

Secondly, the pharmaceutical agents are employed only as needed in the proper concentrations.

Third, the proper topical application of drugs has minimal effect on the body's general systems.

The adverse responses are generally grouped into localized responses -- allergies, rashes, redness, etc. and systemic responses. The drugs with the potential for some real danger involve anti-glaucoma drugs such as Timilol (timoptic) and the anti-inflammatory medications, the glucocortico-steroids.

A recent study -- published in the Journal of Ophthaolmology October, 1986 -- tracks 40 million prescriptions

for Timilol involving 32 deaths and 400 reactions from 1978 to 1985. Over 90% of those reactions could be eliminated with a health history of respiratory and cardiac conditions. The literally one in a million chance of harm can be reduced even further by screening and cooperation with the patient's general physician.

Steroids have potentially dangerous side effects when used for the wrong conditions (specifically viral infection) or for too long a period of unsupervised use. Optometrists can differentiate the salient conditions. Also, patients with a family pre-disposition to adverse reaction must be identified. Steroids of this type suppress the inflammatory response of the eye. They are vital for patient comfort and in controlling complications.

There are risks to any form of treatment. The advantages of that treatment must be evaluated against the risks. Optometrists are qualified to make these evaluations. Beneficial pharmaceuticals are the same drugs whether prescribed by an optometrist or an ophthalmologist.

Optometrists are interested in this legislation so that we may better care for our patients. These people are in our offices now. We are practicing full time in 74 counties of Kansas. The eye care delivery system allows optometric diagnosis, but requires referral to a second office for treatment.

These needless referrals result in a second office call for the patient, more of the patient's time and, often, significant

travel time and expense. Please refer to optometric distribution in Kansas. (Center of booklet.) You will note - ophthalmology is full time in only 24 counties and 70% are in the seven major counties.

You will hear that family practice and primary care physicians can handle these problems. Their distribution is excellent and they do provide much of this primary care. They generally are successful. Many of these conditions are treated by prescription without an examination. Although we don't condone this practice, this demonstrates medicine's general opinion of the relative safety of these medications.

The proper care of the patient dictates that the diagnosis of acute or (red eye) problems must be made with a biomicroscope. In addition, other sophisticated equipment is available in optometric offices and should be used. Patients take eye symptoms to their eye doctor -- and rightly so. The standard of eye care in optometry is and will be higher than that found in Family Practice or most emergency rooms. We are simply better trained and equipped.

As has been mentioned, optometrists are the eye care practitioners for most Kansans. A large number of these patients enter the system of health care through their optometrists. We optometrists routinely refer individuals with hypertension, diabetes, neurological difficulties and other systemic problems to various branches of medicine. This is a good, workable system with the optometrist as the primary eye care doctor.

The ophthalmological myth that optometry isn't in the flow of health care, is simply wishful thinking on their part. We frequently share referrals with physicians.

In similar fashion, the relatively common occurrence of something becoming imbedded on the surface of the eye is a common mishap. An optometrist has an intimate knowledge of the cornea and its functions. The treatment of these problems is within the logical domain of the optometrist.

Optometrists are routinely consulted for red or irritated eyes. Many of these conditions, after diagnosis, are treated with over-the-counter medications or a simple explanation and reassurance.

Optometric practice is involved extensively with contact lens practice. Once a contact lens has been fitted on the eye and provides correct vision, the key in treatment is to monitor the degree of corneal insult. The interference with normal corneal physiology, along with the mechanical damage induced by lenses on the lids, conjunctiva, and cornea must be managed in proper patient care. This case is only possible because the optometrist has an intimate understanding of the anatomy and physiology of the anterior eye, along with the instrumentation needed for examination. The knowledge and instrumentation needed to render therapeutic care are clearly in the realm of optometric practice. Optometrists are currently making clinical decisions on an everyday basis consistent with this type of treatment. The differential diagnosis of mechanical irritation, inflammation, allergies, infections are made every day by

Kansas optometrists. The therapy follows logically once the diagnosis is made. To pretend that optometry can't and doesn't make these decisions, is an insult to a valued profession.

Another concern expressed by medicine involves the existence of different categories of optometrists. Ten years ago, this legislature allowed properly qualified and tested optometrists to use pharmaceuticals for diagnosis. At present, 85% of the active optometrists in Kansas are so licensed. Within the next decade, virtually all optometrists will be uniform in licensure as normal attrition eliminates those not using diagnostic pharmaceuticals. The same will hold true for therapeutic licenses. Optometry will be largely one class at all times. Time will make this extension of services even more uniform.

It should be remembered that all professional and specialties have differences in services offered. Essentially, the patient goes to their doctor so that he may see to their care -- personally, by consultation or referral. My family practitioner may or may not do surgery, provide cardiac care, analysis gastrointestinal problems or neurological symptoms, provide obstetrics or a host of other services. Quite simply, it varies with his training and interest.

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 allocations were distortions or groundless. We can document

that therapeutic legislation doesn't substantially change optometric exposure to malpractice. 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.) I invite you to challenge any allegations made during these hearings.

Charges are made that malpractice rates and availability will become problems.

As all of you know, malpractice rates are not going down for anyone. You know the reasons. The figures are available for North Carolina and West Virginia. The opinion of Poe and Associates, a major insurance broker, is that therapeutic care changes our exposure very little. These documents are available for your examination.

One carrier does have a current policy of dropping out of the market in therapeutic states. That is their decision -- companies are constantly changing their markets. There is no problem in obtaining coverage at reasonable cost.

In all these matters, optometrists wish to practice at their level of competence. The passage of this legislation allows an optometrist to treat when he or she is confident and competent. We will still refer and consult as needed. My attempt to get the best care for my patients means that specialty expertise may be needed. The concept that this legislation is dangerous is purely a smokescreen. Medicine, in

general, is in opposition to any change in their exclusive arrangement. That isn't hard to understand. We must remember, however, that the legislature gives those rights. Medicine has no legislative restriction to expand into new techniques, treatments and procedures as they see fit. Why is it so hard to believe another profession could achieve the knowledge and skills to modify their activities?

In practice, many of us work with ophthalmologists in two way referral and consultation of our patients. However, we are in basic competition for the same routine care patient. Ophthalmology is against any mechanism that dilutes some of their exclusive acts. The passionate arguments about safety are pure demagoguery. The basis of these arguments is ego and economics.

Please consider that the public approves of optometric practice. We are asking for the right to better care for our present patients. We have shown and can prove the efficiency of this concept. We are here to bring the current definition of limited Optometry into the present.

In summary, Kansans will realize improvements in the level of primary eye care with this legislation. I remind you of our educational qualifications. We have the equipment and training. We are geographically accessible. These factors will save Kansans time and money. Please allow us to better care for our patients by passing Senate Bill 113.



Poe & Associates, Inc.

P.O. Box 1348/Tampa, Florida 33601-1348

(813) 222-4100

Telex 52-629

October 28, 1986

Mr. Dan Lex
Wyoming Optometric Association
P. O. Box 2186
Cheyenne, WY 82330

RE: Therapeutic Drug Usage

Dear Mr. Lex:

Thank you for your inquiry as it concerns the subject of therapeutic drug usage and the effect, if any, that such usage within the State of Wyoming would have on the current rate and premium.

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

The current carrier of record, Great American Insurance Companies currently does not charge a premium differential or surcharge for therapeutic drug usage in any of the states in which they are currently providing coverage.

Hopefully, this information will be of use to the Wyoming Optometric Association. Please feel free to call me or write if you need additional assistance.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Stanley R. Kloszewski'. The signature is written in a cursive, somewhat stylized script.

Stanley R. Kloszewski
Senior Vice President

SRK/sy

cc: Bill Reinertson, American Optometric Assoc.

GREAT AMERICAN INSURANCE COMPANY, CINCINNATI UNDERWRITER

RATE SCHEDULE FOR PROFESSIONAL LIABILITY
LIMITS OF LIABILITY OF \$1,000,000 CSL

STATE CODE	OPTOMETRISTS PACKAGE 80994	OPTOMETRISTS MONO 80994	EMPLOYED OPTOMETRISTS 80994	ALL OPTICIANS 80937	SPECIFIED CITY HIGHEST RATE
Alabama	01	300	360	72	58
Alaska	54	360	450	90	72
Arizona	02	432	540	108	86
Arkansas	03	300	360	72	58
California	04	360	450	90	72
Colorado	05	360	450	90	72
Connecticut	06	360	450	90	72
Delaware	07	360	450	90	72
Dist. of Col	08	432	540	108	86
Florida	09	360	450	90	72
Georgia	10	300	360	72	58
Hawaii	52	300	360	72	58
Idaho	11	360	450	90	72
Illinois	12	360	450	90	72
Indiana	13	288	360	72	58
Iowa	14	360	450	90	72
Kansas	15	300	360	72	55
Kentucky	16	300	360	72	58
Louisiana	17	300	360	72	58
Maine	18	360	450	90	72
Maryland	19	360	450	90	72
Mass.	20	300	360	72	58
Michigan	21	360	450	90	72
Minnesota	22	360	450	90	72
Missi.	23	300	360	72	58
Missouri	24	360	450	90	72
Montana	25	360	450	90	72
Nebraska	26	300	360	72	52
Nevada	27	360	450	90	72
New Hampshire	28	360	540	106	86
New Jersey	29	432	540	108	86
New Mexico	30	432	540	108	96
New York	31	432	540	108	86
North Caro.	32	300	360	72	53

Los Ang/SF

Miami/Ft.Lau

Chicago

Boston

Detroit

North Dakota	33	360	450	90	72
Ohio	34	300	360	72	58
Oklahoma	35	300	360	72	58
Oregon	36	360	450	90	72
Penn.	37	432	540	108	86
Puerto Rico	58	N/A	N/A	N/A	N/A
Rhode Island	38	360	450	90	72
South Caro.	39	300	360	72	58
South Dakota	40	360	450	90	72
Tenn.	41	288	360	72	58
Texas	42	360	450	90	72
Utah	43	360	450	90	72
Vermont	44	300	360	72	58
Virginia	45	300	360	72	58
Washington	46	360	450	90	72
West Virg.	47	360	450	90	72
Wisconsin	48	360	450	90	72
Wyoming	49	300	360	72	58

Dallas/
Houston

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.

S P H / W
2-11-87
Attachment 2

Page Two

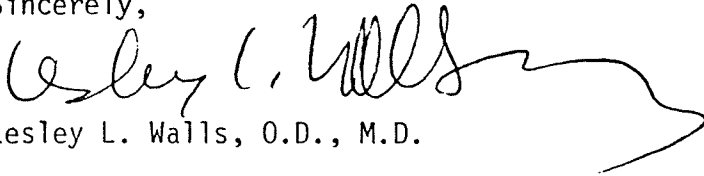
On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. The detailed ocular anatomy,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

A handwritten signature in cursive script that reads "Lesley L. Walls". The signature is written in black ink and is positioned above the typed name.

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

LLW/laj

TESTIMONY

SENATE PUBLIC HEALTH & WELFARE COMMITTEE

FEBRUARY 11, 1987

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

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

I am here this morning to discuss some of the basic elements of optometric education as they relate to the legislation being considered by this committee. I believe that I can assure you that optometrists are far better trained than any other primary health care practitioner with the exception of a resident in ophthalmology to provide therapeutic eye care to the people of Kansas.

*S P & W
2-11-87
attachment 3*

Eighty percent of the students entering optometry school have completed four years of college and hold a baccalaureate degree. Pre-requisite requirements for optometry include basic and advanced biology, physics, chemistry, and a variety of social sciences. These requirements are similar to medicine, dentistry, osteopathy, and podiatry. All schools and colleges of optometry are accredited by the same agencies as other health professions. The Gourman Report, a rating of graduate and professional programs in American universities, gave the 13 schools and colleges of optometry that were evaluated, 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.

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

The basic biomedical courses taught in the schools and colleges of optometry are extensive. They include: Gross Anatomy, Histology, Human Physiology, General Biochemistry, General & Systemic Pathology, Microbiology, and Neurosciences. The intent of these courses is to

give the student an in-depth understanding of how the body is designed, how it works, and what goes wrong when it becomes diseased.

These basic biomedical science courses are directed toward a greater understanding of systemic diseases. Courses in medical urgencies and emergencies and clinical medicine (taught by physicians) discuss the role of the primary care optometrists, including emergency medical care such as CPR, in the management of patients with systemic diseases. Optometrists learn to recognize systemic disease through proper history and patient interview, direct observation, and various clinical signs and tests.

It is important to note that all the biomedical sciences courses taught in other health professional schools are also included in the curricula of the schools and colleges of optometry, and that the quality of the instructors is similar.

Two areas which require special comment include pharmacology and the diagnosis and treatment of ocular diseases. On an average, 156 hours of pharmacology are presented at the schools and colleges of optometry. This is equal to or greater than all other health professions that use therapeutic pharmaceutical agents exclusive of residencies. The courses are taught by faculty with credentials

similar to those teaching pharmacology to medical, dental, osteopathic, and podiatric students. Within these courses, greater emphasis is placed on ocular pharmacology than those courses presented to other health professionals including general physicians. Pharmacology courses in optometry schools emphasize the systemic manifestations of ocular drugs, ocular manifestations of systemic drugs, toxicities and adverse reactions. In essence, optometrists receive more training than all other non-ophthalmologic health care practitioners in ocular pharmacology.

Ocular disease diagnosis and treatment is covered more extensively and comprehensively in optometric curricula than in any other health professional program. The courses include a detailed discussion of the history, symptoms, clinical picture, etiology, prognosis and management related to ocular diseases. Students are presented the basic pathological process of all diseases discussed.

The management of ocular diseases is approached in a manner which supports the role of the optometrists in dealing with these conditions at the primary care level. This is done by emphasizing early vs. advanced conditions, simple vs. complicated conditions, conditions that respond well to treatment vs. resistant diseases, the need for timely referral and most appropriate referral sources, and conditions requiring advanced medical and/or surgical treatment. The

diagnosis and treatment of ocular diseases is taught by highly qualified experts, including board certified ophthalmologists and sub-specialist ophthalmologists.

The greatest change in optometric education over the past fifteen years has been in the clinical training. Clinical training programs at the schools and colleges of optometry begin during the first year of training with maximum patient care exposure during years three and four. A variety of innovative teaching techniques are used to maximize the students' potential exposure to the largest number of eye diseases, their treatment and management. These techniques include closed circuit television and video technology, case conferences, group observations, and grand rounds. All schools and colleges support multi-disciplinary faculties of medical, optometric, ophthalmological, social, psychological, and rehabilitative practitioners and specialists. These disciplines teach optometry students on live clinical patients.

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

At many schools and colleges of optometry, the on-campus clinical training is not the sole source of the students' clinical experiences. As in medicine, an externship program plays a significant role in training. Public, private and community resources with supervised preceptors serve as settings for externs. These would include ophthalmology practices and clinics, health maintenance organizations, military hospitals and clinics, V.A. hospitals, public health hospitals, community teaching hospitals, Indian health services, and multi-disciplinary clinics. Optometric practices in states which currently allow the use of therapeutic drugs to treat eye diseases also are an ideal location for externships.

Continuing optometric education follows the same tenets just described for the professional optometric curriculum. This includes discussion of ocular diseases or conditions from their basic science understanding through their clinical management. Multi-disciplinary teaching settings are also used in continuing education. The Pennsylvania College of Optometry has been extensively involved in continuing education presenting its Ocular Therapy course in 16 states to over 1,500 optometrists.

In reality, the most effective continuing education to update and maintain clinical competency is the less structured and informal process of self-education. Ophthalmic literature is extensive and available to optometrists through medical and/or optometric journals, audiovisual and video programs, and books and monographs.

Optometrists also collaborate with other health professions, including ophthalmologists, on a day-to-day basis with a significant exchange of knowledge and information occurring. One can never underestimate the importance of years of clinical experience which improve the skills and competencies of all health care professionals.

Hopefully, this gives the committee an overview of the current status of optometric education.

Now let us compare the education of optometrists and general physicians as it relates to the treatment and management of eye disease. In a rural state such as Kansas, a high percentage of anterior segment eye disease is being treated by non-ophthalmological physicians. If you compare the training of optometrists with these non-ophthalmological physicians, you will find some startling results. A recent textbook by Jacob T. Wilensky and John E. Reed, both ophthalmologists at the University of Illinois at Chicago, entitled, Primary Ophthalmology, was written to address the

inadequacies of general physicians' training to treat eye diseases. The following are quoted statements from this textbook:

"Most medical students receive little exposure to ophthalmology in medical schools.

"Moreover, residencies and family practices, internal medicine, pediatrics, and emergency medicine commonly fail to correct this deficit.

"A significant number of physicians graduate without ever having been formally taught how to examine an eye or manage common ocular problems.

Unfortunately, the constant comparison made concerning the issue before you is between optometry and ophthalmology. The comparison should be made between optometry, dentistry, podiatry, and general medicine. Optometrists are not attempting to become ophthalmologists. They simply want to practice their profession to the limits of their competencies.

Bill Crawford, O.D.

Educational Background

Total of 12 years of college and graduate level work.

B.S. in mathematics and physics from Miami University in Oxford, Ohio.

M.A. in mathematics and course work requirements for Doctorate from Indiana University.

Chemistry at Wichita State University while stationed at McConnell AFB.

OD from Indiana University including external clinics at Fort Knox, Kentucky, Indianapolis Eye Clinic, and Christian Community Center, two months each.

I too am here to urge your support in updating the Kansas Optometry Law via passage of Senate Bill 113 allowing certified Kansas optometrists to utilize certain topical pharmaceutical drugs in the treatment of various eye diseases.

I have an unusual perspective on this issue, in that for the past six plus years I have been practicing in an HMO setting, and, although I live and practice in Kansas, part of my practice each week is in a state, Missouri, which now allows me to use therapeutic pharmaceuticals.

As Chief of optometry for the Wyandotte/Johnson County and South KC Region of the Prime Health HMO, I am responsible for the primary eye care, of some of your constituents. I practice much of

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my week at the Quivira Crossing Medical Center and would be glad to show you our facilities there and discuss the bill further at your convenience.

I live in Overland Park. Last month, Prime Health opened its new Metcalf Medical Center, Mission, and I will be opening the Eye Care Department there in April.

However, currently the rest of my week is spent practicing in Missouri at the Wornall Medical Center. The reason this is pertinent is that for 1/2 of my week, I am already legally authorized to use these pharmaceuticals which Kansas optometrists are asking permission to use, since Missouri passed its therapeutic bill last year. I feel fully confident in prudently using these agents to treat routine eye conditions, and am well aware of which conditions I am not confident treating, but promptly refer to the Prime Health ophthalmology staff.

In the Health Maintenance Organization (HMO) setting, we of the optometry staff have a very close working relationship with and are actually part of the Medical Staff. The HMO concept is to utilize all health care providers to the full extent of their abilities, in order to provide the optimum quality health care to members at optimum cost efficiency.

Those of our 64,000 members who present to our internists or pediatricians with ocular problems are most often referred to the optometry department for evaluation. These physicians recognize the abilities of modern optometry to utilize the latest ocular diagnostic equipment, especially the slit lamp biomicroscope, to accurately evaluate ocular inflammations and infections.

The vast majority of conditions resolve quickly with no further complications. However, if the initial presentation is more severe, or if resolution does not occur in an expedient manner, the excellent Prime Health ophthalmology staff is called into play, and the patient is referred to them immediately. HMO's nationwide have recognized this system as being the best possible use of the health care knowledge available to our society.

The HMO system nationally uses the Primary Care Provider -- in this care the optometrist -- to the highest of his/her abilities, (at a much lower cost to the HMO and therefore the patient), and frees up the specialist -- in this case the ophthalmologist -- to see those severe cases which he/she needs to see.

This system has proven to be safe, more efficient, and more cost effective over the past 50 years in HMO's, than the previous alternative where the specialist was treating every cold and runny nose. And now the non-HMO patient is being offered this type of health care also, by the passage of bills such as this one.

Personally, in the HMO setting, this bill, as the Missouri bill last year, will not make that much difference in my practice style, since I am already consulted on most of these cases. But if the HMO member/patient can benefit from this system, so can the non-HMO patient, especially the rural patient, who lives down the street from the optometrist, but many miles from an ophthalmologist.

The referral from the HMO internist/pediatrician to the HMO optometrist across the hall, costs the patient nothing in extra

time or expense. But, in the fee-for-service world in which most Kansans live, this involves a trip across town to the optometrist, and one back to get the medication, not to mention the extra office visit fee. So, most internists/pediatricians treat the condition themselves, without really being able to see the eye properly with the biomicroscope, or the patient goes (many miles in many cases) to an ophthalmologist, which involves even higher costs!

In conclusion, the reasons for passage of this bill can be broken down into three main areas - i.e.:

I. Increased Quality of Kansas' Primary Eye Care.

II. Increased accessibility for all Kansas residents to good quality Eye Care.

and

III. Decreased Cost to Kansans seeking Primary Eye Care.

I. I N C R E A S E D Q U A L I T Y

As I stated previously, most care of minor red eyes now is not in the hands of either ophthalmology or optometry, but is done in the office of the general practitioner, internist, or pediatrician.

The optometrist who has had at least four post-college years of

specific ocular training, including rotations through several external clinics where he/she becomes familiar with the treatment of the less healthy patient, and who has much more sophisticated ocular testing equipment in his/her office than would be feasible for a general practitioner to own, is much more qualified and able to treat routine eye infections/inflammations/injuries.

The pharmacology training received by the optometrist is also of equal quality to that of the physician. I quote from the letter written by Dr. Tal Bosin, who taught me pharmacology, and is head of the Pharmacology Section for the Indiana University School of Medicine: "I regularly teach both medical and optometry students. In these classes, I employ the same textbook, lecture notes, course handouts, and examinations, and both groups perform equally well."

The optometrist already sees these red eyes in his office daily, whether he wants to or not. So he/she is much more knowledgeable about them, but is currently legally unable to treat them, and must refer the patient to his/her internist/pediatrician basically for a signature on an Rx, at increased cost and inconvenience to the patient. Those red eyes which could then be better diagnosed by the optometrist on the primary level as needing secondary care, such as surgery or involved medical cases, could be referred on either to general ophthalmologists or directly to ophthalmological subspecialists such as utilizing the total health care dollar to maximum benefit.

II - I N C R E A S E D A C C E S S I B I L I T Y

Optometry is much more accessible than ophthalmology to all Kansans. This is true in urban/suburban areas, but especially true in rural areas.

III - D E C R E A S E D C O S T

In these days of health care cost increases this bill seems like a breath of fresh air - a Bill that will actually reduce health care costs at the same time it is increasing quality and accessibility.

Let your Constituents, the Kansas Health Care Consumer, share in these potential cost savings, and let the ophthalmologist be financially rewarded for his expertise at those expert secondary care levels.

Thank you for your time, your concern for the health care of your Kansas constituency, and, hopefully, for your support of Senate Bill 113.

My name is Greg Besler. I was born and raised in Topeka, Kansas. I received my Bachelor of Science degree from Kansas State University. I attended the University of Houston College of Optometry on a Kansas State Regents contract and graduated in May 1986. I am a practicing optometrist in Overland Park and Gardner, Kansas.

After receiving my B.S. from KSU, I went on to do four years of professional studies at the University of Houston College of Optometry for a total of 8 years of college training.

My courses concentrated on general pathology, pharmacology, detection and treatment of ocular pathology and/or disorders and optics.

Clinical training begins during the first year of study. By the fourth year of studies, students are in clinic four days per week. Students rotate through clinics, including general clinic, contact lens clinic, and ocular disease clinic.

The ocular disease clinic is staffed by optometrists and ophthalmologists, including the former chairman of the ophthalmology department at Baylor University.

This specialty clinic concentrates on treating and managing patients with various eye disease including eye infections and inflammations, cataracts, glaucoma, and retinal disorders. Students are required to spend two years in this clinic. an

In addition to clinical training at the university, all fourth year students are required to do a five-month externship at established hospitals/clinics around the U.S. and Europe. Some of these centers include Veterans Administration hospitals, Indian

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Health Centers, military hospitals, and private eye care referral clinics.

I was fortunate to complete my externship at the VA Medical Center in Topeka, Kansas. The eye clinic, was an integral part of the hospital and we worked closely with the staff physicians. Our responsibilities included the measurement and correction of refractive error and the detection, treatment and management of eye disease and disorders.

All primary eye care was provided by the optometrists for there were no ophthalmologists on staff. The VA did have an ophthalmologist on a consulting basis and he reported to the clinic one morning every two weeks. The ophthalmologist was consulted on surgical cases and glaucoma cases. This clinical situation is similar to other VA's around the country. Optometrists, and in my case, optometry students, are the ones treating red eyes, removing foreign bodies and managing glaucoma. Ophthalmologists in the system provide secondary eye care and surgery. (Glaucoma treatment plans were initiated after consultation with the general physician to avoid systemic complications.)

Externships are designed to provide extensive clinical experience in the detection and treatment of eye disease. My VA experience was no exception!

The following numbers are based on my 5-month externship experience; which was one component of my clinical training. I had nearly 500 patient contacts.

Due to the age and nature of the patient population, over 40% of these patients had some type of ocular disease or disorder.

6% of the patients had some form of glaucoma.

Foreign body removal was performed on 1% of the population.

Finally, drugs were necessary for the treatment and management for 10% of the patients, not including glaucoma cases. These were used primarily for the treatment of ocular infections and inflammations. This is significantly more clinical training in the diagnosis and treatment of eye disease than that of a primary care physician who is treating the same conditions.

In summary, it is necessary to emphasize a number of important points:

1. Clinical training of current optometry students is supervised by optometrists and physicians.
2. Optometrists and optometry students are successfully treating eye disease across the U.S. in Federal Institutions, as well as states where therapeutic drug laws have passed.
3. Isn't it ironic and frustrating that we can perform these services as students, but not as doctors?
4. We are losing good, young OD's to other states because they are not allowed to utilize their full training in Kansas. Almost half of the Kansas students in my class (6/14) decided not to return to Kansas. A number of these graduates are practicing in states with a therapeutic drug law. Furthermore, these are students that the State of Kansas has invested a lot of money in by virtue of a state contract.

Updating Kansas Optometry Law



KANSAS OPTOMETRIC ASSOCIATION

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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

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

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."

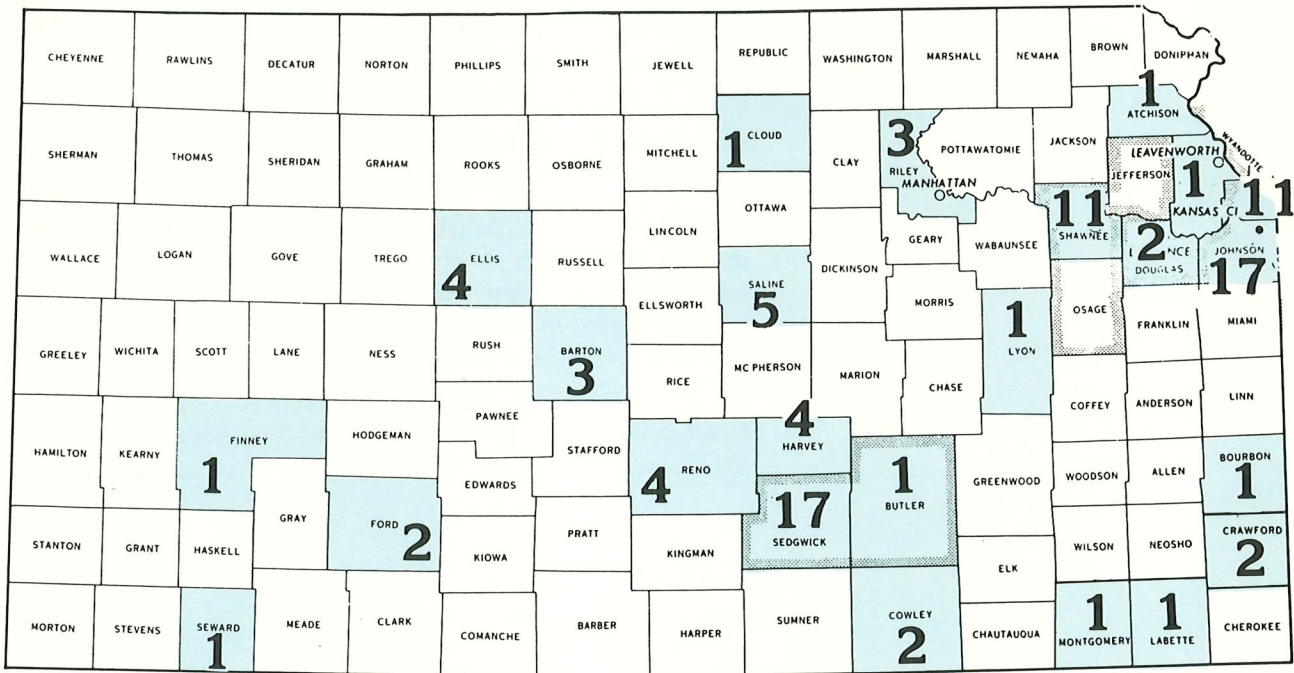
L. A. Winograd, M.D., Editor
"The Ophthalmologist"
March/April 1978

"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

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

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

- 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

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

