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./p.m. on February 13, 1987 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisor of Statutes Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
Lt. Governor Jack E. Walker, also serving as Secretary of Health & Environment
Perry Schuetz, M.D., President, Kansas State Ophthalmological Society
Jerry Slaughter, Executive Director, Kansas Medical Society
Ron Hein, Representative Counsel, Kansas State Ophthalmological Society
Written testimony by George W. Weinstein, M.D.
Written testimony by Harold Riehm, Executive Director, Kansas Osteopathic Association

Others attending: see attached list

The Honorable Jack E. Walker, Lt. Governor, appeared before the committee in his role as Secretary of the Kansas Department of Health and Environment to request introduction of 4 bills by the committee. (1) An act relating to marriage licenses - this bill would use the date of birth consistently throughout the document rather than age in one place and date of birth in another - it would provide for an expiration date of six months following issuance of the license. (attachment 1) Secretary Walker was asked whether or not testing for AIDS could be added to this bill and it was stated that there are a lot of issues involved, namely that the syphilis issue had been to screen and get treatment for those with the disease but there is no cure for AIDS and the cost of testing is high - this issue requires more study. (2) An act enacting Kansas parentage act - this bill would protect the confidentiality of parentage and would change language using illigetimate. (attachment 2) (3) An act repealing KSA-5629 relating to abolishing the advisory committee on food service and lodging - the committee has only had a quorum once in the last 3 years and it is difficult to separate food service and lodging matters. Due to the combining in 1983 the former bureaus of Food and Drugs and Food Service and Lodging, the Advisory Commission on Health also has the authority to advise the Secretary on Food Service and Lodging matters. (attachment 3) (4) An act relating to the Secretary of Health and Environment amending KSA 1986 Supp. 65-1,107 and repealing the existing section - this bill would abolish testing of persons performing serology tests and would approve laboratories performing serological examinations. (attachment 4) Senator Anderson made the motion to introduce these bills with a second by Senator Mulich. Motion carried.

Testimony continued on SB-113 from February 12, 1987. Perry Schuetz, M.D., testified in opposition to SB-113. Dr. Schuetz presented written testimony to the committee February 12, 1987, attachment 4. Dr. Schuetz stated there is no need for the expansion to the level of practice the optometrists are requesting. Dr. Schuetz stated that insurance companies which have traditionally covered optometry have now refused coverage or dramatically increased the rates in states where optometric drug therapy is permitted. It was also stated that optometric education is totally inadequate to practice the medical and surgical eye care as outlined in this bill. Dr. Schuetz told the committee that should legislation be passed he hoped that certain safe guards would be added. These are listed in Dr. Schuetz' written testimony. The doctor also referred to the letter from Patricia L. Turner, M.D., Prime Health, Kansas City, Mo. and asked the committee to read this letter which was presented to the committee February 12, 1987, attachment 5.

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 13, 1987

Jerry Slaughter testified and presented written testimony in opposition to SB-113. Mr. Slaughter stated that he did not feel there was a public outcry for this legislation. The current system works well and the public is assured of competent practioners providing medical eye care. It was further stated that each time the legislator grants a broader scope of practice to another group it fuels the fire and requests multiply. Mr. Slaughter stated that our health care is the best in the world because it has a regulatory structure that assures quality by enforcing strict standards at each level of the pyramid. (attachment 5)

Senator Riley asked questions concerning the meetings that took place last summer, specifically if minutes were taken and what records were kept. Senator Riley requested the transcripts from the meetings between the Ophthalmologists and Optometrists. Dr. Schuetz stated that the transcripts were of poor quality but could be made available and Senator Riley asked that they be furnished. (attachment 11)

Ron Hein commented that testimony from George W. Weinstein, M.D. requested by Senator Morris on February 12, 1987, had been made available to the committee. (attachment 6) In answer to a question from Senator Francisco on February 12, 1987, as to whether money was involved, copies of an article from News Review (attachment 7) was distributed. A chart titled Legislative History of Therapeutic Drug Bills (attachment 8) was distributed showing states where this type of legislation has been introduced and where it has been defeated. Further information was handed to the committee.(attachment 9) Included was a letter from State Farm Fire and Casualty Company concerning their policy of not insuring physicians and also stating that when legislation permits optometrists to treat patients in a similar manner they would be treated as physicians where insurance is involved. Mr. Hein referred to the credentialing statutes, stating that their organization felt this situation would come under those statutes.

Written testimony from Harold Riehm in opposition to SB-113 was presented to the committee. (attachment 10)

The committee will meet February 17, 1987, at 10:00 a.m., room 526-S.
Meeting adjourned at 11:02 a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-13-87

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Charles Bien	Optometrist
Gary Robbins	Ks Optometric Assn
Pete Bramgardt	"
Ron Hein	KSOS
Perry Schuetz	" "
Jerry Slaughter	Ks Medical Society
Rebecca Crenshaw	KSOS
Jim Yonally	KOA
Albert Liemoine	Ks Ophth. Society
Walt Bettis	Ks Academy of Family Physicians
Harold Riehm	Ks. Assn Osteopathic Med
Adrienne V. Prokop	American Society of Ophthalmic Registered Nurses - Eastern Ks Chapter
Bill Henry	Ks Optometric Association
Jim McBride	Observer
Keith R Landis	Christian Science Committee on Publication for Kansas
Tim Ternes	Intern / Sen Talkington
Phil Anderson	Budget Division
John Marvin	Observer
Larry Luttjohann	Kansas Optometric Assn.
John Peterson	Ks Optometric Assn
Larry E Harris	Ks Optometric Assn.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-13-87

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Charles V. Hamm	KDH&E
Jan Walker, MD	KDH&E

1-?-87

____________BILL NO.______

BY____________________

AN ACT relating to marriage licenses; amending K.SA. 23-106 and K.S.A. 23-107 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 23-106 is hereby amended to read as follows: K.S.A. 23-106. The clerks of the district courts or judges thereof, when applied to for a marriage license by any person who is one of the parties to the proposed marriage and who is legally entitled to a marriage license, shall issue a marriage license in substance as follows:

MARRIAGE LICENSE

(Name of place where office located, month, day and year.)

TO ANY PERSON authorized by law to perform the marriage ceremony, Greeting:

You are hereby authorized to join in marriage A B of ____________, ~~aged~~ date of birth ______, and CD of ____________, ~~aged~~ date of birth ______, (and name of parent or guardian consenting), and of this license, duly endorsed, you will make due return to this office immediately after performing the ceremony.

E F, (title of person issuing the license).

No clerk or judge of the district court shall issue a marriage license before the third calendar day (Sunday and holidays included) following the date of the filing of the application therefor in his or her office except that in cases of emergency or extraordinary circumstances, a judge of the district court

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attachment 1

may upon proper showing being made, permit by order of the court the issuance of such marriage license without waiting said three days. In each district court there shall be kept a record of all applications filed for marriage licenses, which record shall show the name of the person applying for such license and the date of the filing of such application and the names of the parties to the proposed marriage. No clerk or judge shall issue a license authorizing the marriage of any eprson under the age of eighteen (18) years, except with the consent of his or her father or mother, or, if both be dead or incapable, his or her guardian, as the case may be, if she or he has one, which consent, if not given at the time in person, shall be evidenced by a certificate in writing subscribed thereto and duly attested. Where the applicants or either of them are under age and their parents are dead and there is no legal guardian then a judge of the district court may after due investigation give consent and issue the license authorizing the marriage. Where such consent shall have been given as herein provided, no license shall be issued to any person under the age of eighteen (18) years without the consent of the judge in addition thereto. The judge or clerk may issue a license upon the affidavit of the party personally appearing and applying therefor, to the effect that the parties to whom such license is to be issued are of lawful age, as required by this section, and the judge is hereby authorized to administer oaths for that purpose.

Every person swearing falsely in such affidavit shall be deemed guilty of a violation of this act and shall be punished by a fine not exceeding five hundred dollars ($500). A clerk or judge of the district court shall state in every license the ~~age~~ birth dates of the parties applying for the same, and if either or both are minors, the name of the father, mother, or guardian consenting to such marriage. Every marriage license shall expire at the end of six months from the date of issuance if the

marriage for which the license was issued does not take place within the six-month period of time.

Sec. 2. K.S.A. 23-107 is hereby amended to read as follows: K.S.A. 23-107. The forms for license shall be furnished by the secretary of health and environment and shall contain a part in duplicate to be detached and issued to the applicant therefor for delivery to the person who performs the marriage ceremony ~~and-also--a-part--to-remain-as-a-stub-for-the-record-of-the-clerk or-judge~~.

Sec. 3. K.S.A. 23-106 and K.S.A. 23-107 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

Analysis/Fiscal Impact: Date: January 21, 1987

KDHE REVIEW OF LEGISLATION

S.B.__________

H.B.__________

Summary/Background:

K.S.A. 23-106 requires the date of birth rather than age on the marriage license. Presently there is no expiration date of the license.

Currently the marriage license is a three-part form. A stub portion to be retained by the clerk of the court. A second part containing only statistical information and then the license itself. In addition, a duplicate of the license portion is issued and retained by the bride and groom.

The Clerks of the District Court Advisory Council have encouraged the proposed changes in the past.

Issues/Concerns:

Changing the age item to date of birth would eliminate the present confusion as to what age is to be entered on the license--the age at the time of application, at the time the license was issued or at the time of the marriage. Entering the date of birth would, therefore, improve the accuracy of the recorded facts of marriage and would conform with the recommended standard format of marriage certificates.

Because there is no expiration date of marriage licenses conceivably a couple could use the license anytime during their lifetime. This means that the court and the state must retain the marriage license records indefinitely, even though the license is not returned within a reasonable length of time.

The present statutory requirement does not allow us the flexibility to develop and adopt a license form similar to other states during the upcoming revision process--which occurs nationally every ten years. The present three-part form is very inefficient in that it requires the recording of a number of items of information several times. It also is conducive to error in that one portion requires the date of birth and the other asks for the age, this often results in a discrepancy in this information which must be queried by staff thus requiring more processing time. Most frequently the date of birth is accurate.

Proposals/Recommendations:

This bill is basically a clean-up bill. All issues addressed will assist in making the marriage license registration process more efficient and less confusing; therefore, we recommend support.

Fiscal Impact:

Fiscal impact would be insignificant as we will be revising the marriage license forms prior to January 1, 1989 anyway. There would be a marginal increase in marriage license fees collected because some applicants would let their license expire and then have to secure a new one; however, almost all licenses that are not returned within six months are never used.

License No. 150088

State File Number

STATE OF KANSAS

THE KANSAS STATE DEPARTMENT OF HEALTH AND ENVIRONMENT

Office of Vital Statistics

D. C. No.________

Marriage License

In the District Court of ________ County. ________ 19__

To Any Person in the State of Kansas Authorized by Law to Perform the Marriage Ceremony, Greetings.

YOU ARE HEREBY AUTHORIZED TO JOIN IN MARRIAGE

________ of ________ Age ____

(Name of Groom) (Residence—City & State)

________ of ________ Age ____

(Name of Bride) (Residence—City & State)

with the consent of ________

(Name of parent or guardian consenting)

[SEAL]

and with this license duly endorsed, you will make return to my office at ________, Kansas, within ten days after performing the ceremony.

____

Name and Title of Court Official

ENDORSEMENT

Signatures of Witnesses:

____

____

DATE RECEIVED BY DISTRICT COURT________ 19__

DATE RECORDED BY DISTRICT COURT________ 19__

NOTE.—After recording, the judge shall forward this original marriage license to the State Registrar, Topeka, Kansas, not later than the third day of following month.

TO WHOM IT MAY CONCERN:

I hereby certify that I, the undersigned, performed the ceremony joining in marriage the above named couple on the____ day of________, 19__, at ____ Kansas, in________County. My credentials are recorded in the D. C.'s office of________ Co., Ks

Signed ________

Title ________

Address ________

TYPE OR PRINT IN PERMANENT BLACK INK
FOR INSTRUCTIONS SEE HANDBOOK

U.S. STANDARD

LICENSE AND CERTIFICATE OF MARRIAGE

LICENSE NUMBER — STATE FILE NUMBER

GROOM

1. GROOM'S NAME *(First, Middle, Last)*			2. AGE LAST BIRTHDAY
3a. RESIDENCE—CITY, TOWN, OR LOCATION			3b. COUNTY
3c. STATE	4. BIRTHPLACE *(State or Foreign Country)*		5. DATE OF BIRTH *(Month, Day, Year)*
6a. FATHER'S NAME *(First, Middle, Last)*	6b. BIRTHPLACE *(State or Foreign Country)*	7a. MOTHER'S NAME *(First, Middle, Maiden Surname)*	7b. BIRTHPLACE *(State or Foreign Country)*

BRIDE

8a. BRIDE'S NAME *(First, Middle, Last)*		8b. MAIDEN SURNAME *(If different)*	9. AGE LAST BIRTHDAY
10a. RESIDENCE—CITY, TOWN, OR LOCATION			10b. COUNTY
10c. STATE	11. BIRTHPLACE *(State or Foreign Country)*		12. DATE OF BIRTH *(Month, Day, Year)*
13a. FATHER'S NAME *(First, Middle, Last)*	13b. BIRTHPLACE *(State or Foreign Country)*	14a. MOTHER'S NAME *(First, Middle, Maiden Surname)*	14b. BIRTHPLACE *(State or Foreign Country)*

SIGNATURES

WE HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF OUR KNOWLEDGE AND BELIEF AND THAT WE ARE FREE TO MARRY UNDER THE LAWS OF THIS STATE.

15. GROOM'S SIGNATURE	16. BRIDE'S SIGNATURE
▶	▶

LICENSE TO MARRY

This License Authorizes the Marriage in This State of the Parties Named Above By Any Person Duly Authorized to Perform a Marriage Ceremony Under the Laws of the State of ________________.		17. EXPIRATION DATE *(Month, Day, Year)*
18. SUBSCRIBED TO AND SWORN TO BEFORE ME ON: *(Month, Day, Year)*	19. SIGNATURE OF ISSUING OFFICIAL ▶	20. TITLE OF ISSUING OFFICIAL

CEREMONY

21. I CERTIFY THAT THE ABOVE NAMED PERSONS WERE MARRIED ON: *(Month, Day, Year)*	22a. WHERE MARRIED—CITY, TOWN, OR LOCATION	22b. COUNTY
23a. SIGNATURE OF PERSON PERFORMING CEREMONY ▶	23b. NAME *(Type/Print)*	23c. TITLE
23d. ADDRESS OF PERSON PERFORMING CEREMONY *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*		
24a. SIGNATURE OF WITNESS TO CEREMONY ▶	24b. SIGNATURE OF WITNESS TO CEREMONY ▶	

LOCAL OFFICIAL

25. SIGNATURE OF LOCAL OFFICIAL MAKING RETURN TO STATE HEALTH DEPARTMENT	26. DATE FILED BY LOCAL OFFICIAL *(Month, Day, Year)*
▶	

CONFIDENTIAL INFORMATION. THE INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD.

	27. NUMBER OF THIS MARRIAGE—First, Second, etc. *(Specify below)*	28. IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED: By Death, Divorce, Dissolution, or Annulment *(Specify below)*	28. Date *(Month, Day, Year)*	29. RACE—American Indian, Black, White, etc. *(Specify below)*	30. EDUCATION *(Specify only highest grade completed)* Elementary/Secondary (0-12)	30. College (1-4 or 5+)
GROOM	27a	28a	28b	29a	30a	
BRIDE	27b	28c	28d	29b	30b	

1-7

1-7-87

BILL NO.

BY

AN ACT enacting the Kansas parentage act; amending K.S.A. 65-2422 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-2422 is hereby amended to read as follows: 65-2422. (a) The records and files of the division of health pertaining to vital statistics shall be open to inspection, subject to the provisions of this act and regulations of the secretary. It shall be unlawful for any officer or employee of the state to disclose data contained in vital statistical records, except as authorized by this act and the secretary and it shall be unlawful for anyone who possesses, stores or in any way handles vital statistics records under contract with the state to disclose any data contained in the records, except as authorized by law.

(b) No information concerning the birth of a child shall be disclosed in a manner that enables determination ~~of-whether~~ that the ~~child's~~ child ~~parents-were--married-at--the-time--of-the child's-birth~~ was born out of wedlock, except upon order of a court in a case where the information is necessary for the determination of personal or property rights and then only for that purpose.

(c) The state registrar shall not permit inspection of the records or issue a certified copy of a certificate or part thereof unless the state registrar is satisfied that the applicant therefor has a direct interest in the matter recorded and that the information contained in the record is necessary for the determination of personal or property rights. The state registrar's decision shall be subject, however, to review by the secretary or a court under the limitations of this section.

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attachment 2

(d) The secretary shall permit the use of data contained in vital statistical records for research purposes only, but no identifying use of them shall be made.

(e) Subject to the provisions of this section the secretary may direct local registrars to make a return upon the filing of birth, death and stillbirth certificates with them of certain data shown thereon to federal, state or municipal agencies. Payment by those agencies for the services may be made through the state registrar to local registrars as the secretary directs.

(f) On or before the 20th day of each month, the state registrar shall furnish to the county election officer of each county, without charge a list of deceased residents of the county who were at least 18 years of age and for whom death certificates have been filed in the office of the state registrar during the preceding calendar month. The list shall include the name, age, or date of birth, address and date of death of each of the deceased persons and shall be used solely by the election officer for the purpose of correcting records of their offices.

(g) No person shall prepare or issue any certificate which purports to be an original, certified copy or copy of a certificate of birth, death or fetal death, except as authorized in this act or regulations adopted under this act.

Sec. 2. K.S.A. 65-2422 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Analysis/Fiscal Impact: Date: January 20, 1987

KDHE REVIEW OF LEGISLATION

S.B.__________

H.B.__________

Summary/Background:

K.S.A. 65-2422 was amended during the 1985 legislative session per the Parentage Act, to remove any reference to illegitimacy on birth certifications made to applicants. In doing so the wording was changed to read: "No information concerning the birth of a child shall be disclosed in a manner that enables determination of whether the child's parents were married at the time of the child's birth...."

Issues/Concerns:

As per the above, K.S.A. 65-2422 now requires special handling of every certified copy request for birth certificates of individuals born between 1911 and 1948 because those certificates contain marital information in the portion of the certificate to be certified. The special handling requires that a copy be produced from the microfilm, marital information deleted, and a second copy produced from the first and certified.

In many cases the original copy produced from the microfilm is barely legible which means the second copy run is even more illegible. Often, especially with older documents, we must perform the task a number of times to acquire a copy that is readable. To date we are averaging about 1600 certified copies of birth certificates per month for the 38-year period involved.

Special handling requires additional staff time, supplies and machine time.

Proposals/Recommendations:

Since one of the objectives of the Parentage Act was to protect the confidentiality and privacy of those individuals born out-of-wedlock, it seems the problems could be resolved simply by changing the wording as proposed. Such a change would allow staff to process the majority of requests as normal and would require special handling only of those certificates whereby the individual was born out-of-wedlock; therefore, we would still be protecting the confidentiality of those that were born out-of-wedlock. We, therefore, recommend the wording change as indicated in K.S.A. 1985 Supp. 65-2422b of the drafted bill.

Fiscal Impact:

There would be no direct fiscal impact from the passage of this amendment in that there would be no need to adjust the Department's budget.

1-12-87

_______________ BILL NO. _____

By ____

AN ACT repealing K.S.A. 75-5629 relating to abolshing the advisory committee on food service and lodging.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 75-5629 is hereby repealed.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

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Attachment 3

KDHE REVIEW OF PROPOSED LEGISLATION

Advisory Committee on Food Service and Lodging Standards

Summary/Background:

Adoption of this proposed bill would result in abolition of the Advisory Committee on Food Service and Lodging Standards established by K.S.A. 75-5629. This committee was formed in 1975 following the abolition of the Food Service and Lodging Board with responsibilities of the former Board transferred to the Secretary, Kansas Department of Health and Environment. The members of the committee are appointed by the Governor and represent the food service and lodging industries as well as consumer interests. Mandated meetings of the committee were changed from monthly to quarterly effective July 1, 1983. During the first few years of existence, the committee was very active and assisted the Secretary in dealing with many policy issues pertaining to budgetary needs, regulation promulgation and program implementation.

Issues/Concerns:

For a number of years (since about 1980) the workload of the committee has decreased substantially. This reduction in workload has resulted because policy questions regarding the food service and lodging licensing program have been resolved. The committee has only convened a quorum once in the last three years. As a result of intra-agency reorganization, it is difficult to separate food service and lodging matters from other departmental functions for consideration by the committee. This has resulted through the combination in 1983 of the former bureaus of Food and Drug, and Food Service and Lodging. The Advisory Commission on Health also has the authority to advise the Secretary on Food Service and Lodging matters.

Proposals/Recommendation:

In 1982 the Advisory Commission on Health conducted audits of the bureaus of Food and Drug, and Food Service and Lodging. The recommendations of the Advisory Commission on Health audit included abolition of the Advisory Committee on Food Service and Lodging Standards and at the same time authorizing the Secretary to convene ad hoc committees as necessary.

Recommend the Committee be abolished.

Fiscal Impact:

Abolition of the Advisory Committee on Food Service and Lodging Standards would have no significant fiscal impact on the KDHE.

~~Contamination~~ Continuation of a fully active committee would have a fiscal impact of $5,780 annually. The attached fiscal impact summary estimates annual costs for a full functioning active committee.

FISCAL IMPACT SUMMARY

Advisory Committee on Food Service and Lodging Standards

The Food Service and Lodging Advisory Committee was created to consult with and advise the secretary of health and environment on matters relating to food service and lodging standards. The committee consists of nine members.

Following is a summary of the fiscal impact related to the quarterly meeting activities of the committee, FY 1987 and FY 1988:

Lodging	
Provides for lodging costs, one night per member, $40 per night	$ 360
Per Diem	
Provides for food costs, six quarters per member, $4 per quarter	216
Mileage	
Provides for transportation costs, average 300 miles per member, 20.5¢ per mile	554
Compensation	
Members are compensated $35 for each day of actual attendance at meetings	315
Total Cost Per Meeting	$1,445
Total Cost, FY 1987 - One meeting each, third and fourth quarters	$2,890
Total Cost, FY 1988 - One meeting each, first, second, third and fourth quarters	$5,780

1-22-87

DP/X1

1-14-87

_______________ BILL NO. ______

BY ______________________________

AN ACT relating to the secretary of health and environment, amending K.S.A. 1986 Supp. 65-1,107 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1986 Supp. 65-1,107 is hereby amended to read as follows: 65-1,107. The secretary of health and environment is hereby authorized and empowered to promulgate rules and regulations establishing:

(a) The procedures and qualifications for ~~the-registering and~~ approving ~~of~~ laboratories performing serological examinations for syphilis;

~~(b)--the-procedures-and-methods-of-examination--and-approval of-person-performing-serology-tests-in-approved-laboratories;~~

~~(c)~~ (b) the procedures, qualifications of personnel and standards of performance in the testing of human breath for law enforcement purposes, including procedures for the periodic inspection of apparatus, equipment and devices, other than preliminary screening devices, approved by the advisory commission for the testing of human breath for law enforcement purposes;

~~(d)~~ (c) the requirements for the training, certification and periodic testing of person who operate apparatus, equipment or devices, other than preliminary screening devices, for the testing of human breath for law enforcement purposes;

~~(e)~~ (d) criteria for preliminary screening devices for testing of breath for law enforcement purposes, based on health and performance considerations; and

~~(f)~~ (e) a list of preliminary screening devices which are

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Attachment 4

approved for testing of breath for law enforcement purposes and which law enforcement agencies may purchase and train officers in the use of as aids in determining probable cause to arrest and grounds for requiring testing pursuant to K.S.A. 8-1001 and amendments thereto.

Sec. 2. K.S.A. 1986 Supp. 65-1,107 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

REVIEW OF LEGISLATION

DATE ______________

HB ______________

SB ______________

I BACKGROUND

KSA 65-1,107 IS THE ENABLING STATUTE FOR THE CERTIFICATION PROGRAMS CONDUCTED BY THE DEPARTMENT OF HEALTH AND ENVIRONMENT RELATING FIRST TO THE APPROVAL OF CLINICAL LABORATORIES AND PERSONNEL PERFORMING SEROLOGICAL TESTS AND SECONDLY THE BREATH ALCOHOL PROGRAM.

THE PROPOSED AMENDMENT TO KSA 65-1,107 WOULD ABOLISH THE REQUIREMENT FOR PERSONNEL TO BE APPROVED TO PERFORM SEROLOGICAL TESTS. LABORATORIES WOULD CONTINUE TO BE APPROVED BY THE DEPARTMENT OF HEALTH AND ENVIRONMENT.

II ISSUES/CONCERNS

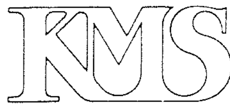
THE CURRENT LEGISLATION REQUIRING THE APPROVAL OF PERSONS PERFORMING SEROLOGICAL TESTS IS INCONSISTENT WITH GENERALLY ACCEPTED LABORATORY MANAGEMENT. THERE ARE NO REQUIREMENTS UNDER MEDICARE APPROVAL OR CLIA (CLINICAL LABORATORY IMPROVEMENT ACT OF 1967) LICENSURE FOR APPROVING PERSONS FOR A SPECIFIC TEST. FURTHERMORE, APPROVING A LIMITED NUMBER OF PERSONS IN EACH LABORATORY DOES NOT ASSURE THAT PATIENT TESTS ARE ACTUALLY BEING PERFORMED BY THOSE PERSONS.

ABOLISHING THE REQUIREMENT FOR PERSONS TO BE APPROVED FOR A SPECIFIC TEST WILL ALLOW CLINICAL LABORATORIES GREATER FLEXIBILITY

IN THEIR PERSONNEL MANAGEMENT WITHOUT JEOPARDIZING THEIR "FULL APPROVAL" STATUS AS A LABORATORY.

III Recommendation:

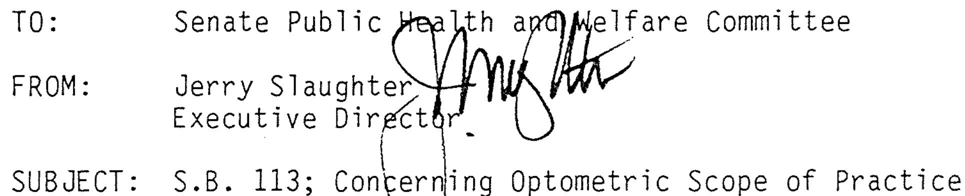
IT IS RECOMMENDED THAT THE REQUIREMENT FOR APPROVING PERSONS TO PERFORM SEROLOGICAL TESTS BE ABOLISHED. THIS CHANGE SHOULD NOT JEOPARDIZE THE QUALITY OF DATA PRODUCED IN APPROVED LABORATORIES.



KANSAS MEDICAL SOCIETY

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

February 12, 1987



TO: Senate Public Health and Welfare Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: S.B. 113; Concerning Optometric Scope of Practice

We appreciate the opportunity to comment on S.B. 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?

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attachment 5

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 treating glaucoma, a serious problem for many of our citizens. The original proposal last year included the authority to perform surgery. Where will their demands, their wish list 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 S.B. 113 adversely. Thank you for the opportunity to appear and register our opposition to this legislation.

JS:nb

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March 18, 1985

West Virginia
University

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

Oculoplastic Surgery
John V. Linberg, M.D.

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

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

Laboratory:

Pharmacology
Brenda K. Colasanti, Ph.D.

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

Retinal Function
Robert R. Hobson
Nancy Taylor

Clinic:

Ophthalmic Photography
Allan R. Jones

Clinic Nurse
Jean Lofflin, R.N.

Ophthalmic Technicians
Michelle Michael
Nancy Cronin
Janet Grasso

Orthoptics
Margaret Hodous

Office Manager
Tammy Miller

Staff Writer
Gail Adams

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

Dear Members of the Committee:

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

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

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

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

SPH&W
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attachment 6

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

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

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

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

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

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

Sincerely yours,

George W. Weinstein, M.D.

GWW/tkm

NATIONAL PANEL

Surgery: The next frontier

Optometrists are tired of referring patients with minor problems such as superficial corneal foreign body, stye, chalazion, epiphora, and ingrown lashes. O.D.'s want to handle these problems in their own offices, and they're ready and willing to do whatever's necessary to reach that goal.

That's the story from our 500-member National Panel of Doctors of Optometry. This month, 249, or 49 percent, responded.

Nearly two thirds of our panelists say qualified O.D.'s should be allowed to do minor surgery.

Why? The most important reason is that it would be good for patients. Seventy percent of our panelists believe optometric surgery would benefit patients.

Right now, in communities where there are no ophthalmologists, or only very busy ophthalmologists, patients with problems often have to go to the hospital emergency room. They'd be better off going to their optometrist.

"Optometrists are better qualified to handle these problems than a general practitioner," says Yankton, S.D. optometrist P.S. Anderson. They're often better equipped, too. "In my area," says Exeter, Calif. optometrist Terence Miller, "most foreign bodies are removed by general practitioners with no magnification or dilation to check for penetration." Emergency room M.D.'s in Angels Camp, Calif. frequently borrow a slit lamp from local optometrist Jack Hall for foreign body removal.

Even in communities where there are available ophthalmologists, optometric surgery would make things more convenient for patients. "Having to seek a second practitioner constitutes an annoyance to many persons," says Oaklyn, N.J. optometrist Arnold Kohler. And "patients would save money by not having to pay twice for the same diagnosis," adds Milford, Del. panelist W. Warmouth.

Two thirds of our panelists say surgery would also be good for optometry.

Obviously, surgery

IN THE NEWS

Solution drought

Demand for hydrogen peroxide disinfection is so intense that Ciba-American Optical, maker of Aosept, is having trouble keeping up with it.

Don LoVotere, the company's marketing vice president, says the company put on an extra shift to produce more of the solution, and says the product will soon become more available.

But a recent spot check indicates doctors in Florida, Colorado, Texas and Michigan are still having trouble stocking their offices, and patients are still having trouble finding the product in drug stores.

The hydrogen peroxide market is so attractive that many other companies have jumped on the bandwagon.

Aosept's first rival seems likely to be CooperVision's Mirasept system, which got FDA approval in January. ■

Responding to weak sales and doctor complaints, Sola-Syntex pulled its Synsoft translating soft bifocal from the market, and sold Salvatori Opthalmics, developer of the lens, back to its original owner.

Doctors can still get the lens from Salvatori Ophthalmics. ■

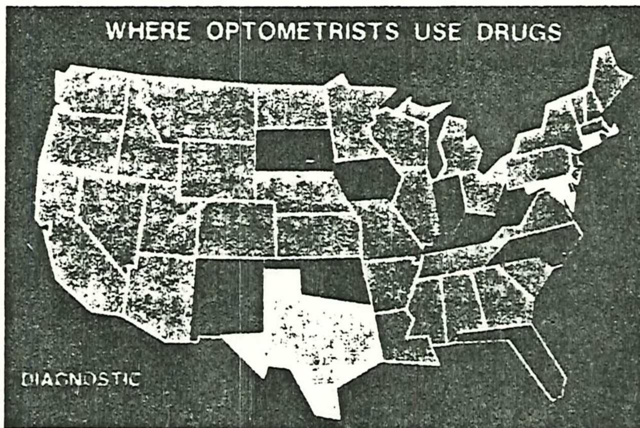
DRUG UPDATE

Two states win TPA's

Optometrists in two states last month won the right to use therapeutic drugs.

Kentucky Gov. Martha Layne Collins signed into law a permissive bill allowing O.D.'s to use any topical ocular pharmaceuticals, and to remove superficial foreign bodies.

A bill passed by the South Dakota legislature gives optometrists similar latitude, but bars O.D.'s from treating



glaucoma and iritis, and somewhat restricts steroid use. At presstime, Gov. William Janklow had not signed the bill, but reportedly had promised to do so.

Ten states now permit optometrists to use therapeutic drugs; 46 states O.D.'s to use diagnostic drugs. ■

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NATIONAL PANEL

Too much, too soon

Doctors may be gung-ho on doing minor eye surgeries. But most are not interested in doing laser surgery, at least not right now.

When we asked members of our national panel whether they thought O.D.'s would be doing laser surgery in the next 10 years, just 12 percent said yes. Two thirds said no, and another 23 percent said they didn't know.

Why aren't optometrists interested?

- Laser surgery is too complicated, and often involves conditions best managed by a physician. Optometrists shouldn't do laser surgery "until they can manage cystoid macular edema, bleeding hyphema and retinal detachments," says Daniel Lee, a Dayton, Ohio optometrist who is studying to be an ophthalmologist.
- Lasers and attendant equipment such as fluorescein angiography is too expensive for the average optometrist, says a West Virginia O.D.
- Winning legislative approval for laser use would be too difficult and too expensive. An Illinois optometrist says a drive for laser surgery would make ophthalmologists "scream louder than we've ever heard them." ■

NATIONAL PANEL

Surgery: The next frontier

would increase income. The typical optometrist sees about 40 patients each year who require minor eye surgery. Yet right now, most must refer these patients out.

Surgery would also help doctors keep patients. A New Jersey O.D. complains that when he refers patients out for minor surgery, "they do not return or refer other patients."

Most panelists think minor surgical capabilities would fix this problem. Surgery would "increase our income and elevate our stature," says Fredericksburg, Va. optometrist Frederick Wills III. "That will bring more patients into our offices for routine eye care." And, says Ashland, Ky. optometrist John Morton: "Fewer patients would be stolen."

The only problem is that right now, most state laws do not allow optometrists to perform minor surgery. Though 14 percent of all our panelists can legally use therapeutic drugs, only 4 percent say their state law allows them to do any surgery.

How can doctors overcome this problem? One step is getting the proper education to do minor surgery. More than a fourth say they're already qualified to do minor surgery. Fifty percent say they would be willing to undergo training to learn how. Says Worth, Ill. optometrist John Nolan: "M.D.'s do not have a franchise on education."

The next step is to conduct a campaign to convince state legislators that optometrists should be permitted to do minor surgery. Exactly half of our panelists say they'd contribute to such a campaign.

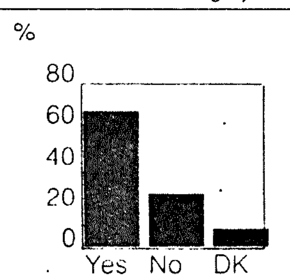
In all, most optometrists are optimistic about their chances. When panelists try to predict what they'll be doing in the next 10 years:

- Three fourths say O.D.'s will routinely be removing foreign bodies;
- Slightly more than half say O.D.'s will routinely drain styes;
- About a third think O.D.'s will routinely remove papillae and chalazions, and dilate the lacrimal duct;
- Several say optometrists will be epilating troublesome eyelashes.

Are there any drawbacks to getting involved in minor surgery? Yes, there are.

One important concern is keeping skills. Some doctors worry that optometrists won't see enough minor surgery to stay in practice. "I'd rather have my chalazion removed by an M.D. who performs 10 a week rather than by an O.D. who does 10 a year," says Budd Lake, N.J. optometrist Randolph Brooks.

TO CUT OR NOT?
Should O.D.'s do surgery?



Another problem is the cost of doing surgery. O.D.'s would have to undergo training, and buy equipment such as reclining exam chairs, foreign body spuds, and rust ring drills. O.D.'s also would probably have to pay higher malpractice premiums. "On the one hand, surgery would increase our patient pool," says a California O.D. "On the other, the malpractice exposure and costs would escalate precipitously." Faced with such a choice, Alma, Mich., optometrist L. Church says optometric surgery "does not make economic sense."

Some doctors also oppose minor surgery on philosophic grounds, saying that a movement to surgery may shift interest away from other services, such as vision therapy. "As it is, there are not enough O.D.'s to work in our historical specialties of behavioral care and vision training," says Rock Island, Ill. optometrist Brent Nielsen.

Finally, some think surgery will make the profession too complicated. A Virginia O.D. says surgery will place "more stress" on O.D.'s.

Still, most optometrists think the benefits of doing minor surgery outweigh the problems, and look forward to achieving the freedom that M.D.'s enjoy. Says Atlantic City, N.J. optometrist Larry Fuerman "It would be nice to use every tool available to help patients." ■

7-2

7/17/86

LEGISLATIVE HISTORY OF THERAPEUTIC DRUG BILLS

Forty-three therapeutic drug bills were introduced in 24 states from 1973 through 1986. Thirty-one bills were defeated and 11 bills were enacted into laws (1 bill is still pending).

YEAR	STATE	DEFEATED	ENACTED	PENDING	CARRYOVER
1973	North Carolina	X			
1976	West Virginia		●		
1977	Mississippi	X			
	North Carolina		●		
1981	Florida	X			
	Oregon	X			
	Tennessee				*
1982	Florida	X			
	Kentucky	X			
	Tennessee	X			
1983	Alabama	X			
	Alaska				*
	Florida	X			
	Nebraska				*
	New Jersey	X			
	Oregon	X			
	Tennessee				*
1984	Alaska	X			
	Kentucky	X			
	Nebraska	X			
	New Jersey				*
	Oklahoma		●		
	Rhode Island	X			
	Tennessee	X			

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YEAR	STATE	DEFEATED	ENACTED	PENDING	CARRYOVER
1985	Alabama	X			
	Arizona	X			
	Iowa		●		
	Mississippi	X			
	Nebraska				*
	New Jersey	X			
	New Mexico		●		
	Oregon	X			
	Pennsylvania				*
	Rhode Island		●		
	South Dakota	X			
	Tennessee				*
	Utah	X			
1986	Florida		●		
	Kansas	X			
	Kentucky		●		
	Louisiana	X			
	Mississippi	X			
	Missouri		●		
	Nebraska		●		
	New Jersey			?	
	Pennsylvania	X			
	South Dakota		●		
	Tennessee	X			
	Utah	X			
	Virginia	X			
	Washington	X			

* Carried over to next session

State Farm Fire and Casualty Company
112 EAST WASHINGTON STREET
BLOOMINGTON, ILLINOIS 61701

RECEIVED
JAN 15 1987
CARPENTER, HEIN, CARPENTER, & WEIR,
CHARTERED

R. L. ODMAN
ASSISTANT VICE PRESIDENT
PHONE (309) 766-5906

January 13, 1987

Ms. Rebecca S. Crenshaw
Carpenter, Hein, Carpenter & Weir, CHTD
5425 SW 7th
P.O. Box 4287
Topeka, Kansas 66604

Dear Ms. Crenshaw:

You wrote to Loretta Forsee in our Columbia office to inquire as to State Farm's policy for underwriting optometrists who are allowed by legislation to prescribe various drugs.

We do not write medical malpractice insurance on physicians as this is a specialty line of insurance written by only a few companies with expertise in underwriting and rating as well as handling claims. When legislation permits optometrists to treat patients in a manner similar to how they would be treated by a physician, we believe that insurance coverage should be provided by a company with an in depth knowledge of this field.

Yours very truly,

R.L. Odman
Ass't. Vice President

RLO:ds

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2-13-87
attachment 9

NEWS

from Optical Index Vol. 61 #6 June 86

PREMIUMS ARE ON THE RISE

Insurance Crisis Reaches ODs

THE SPREAD OF MALPRACTICE suits—and the rise of malpractice insurance premiums—is one of the hottest issues in healthcare. For medical doctors, especially gynecologists, insurance premiums of $100,000 a year are not uncommon. The country's insurance crisis is affecting everyone—municipalities, manufacturers, even lawyers. Optometrists, who pay much lower premiums, are no exception to the rule.

Faced with competition from chains, optometrists are expanding their practices, prescribing therapeutic drugs, and diagnosing eye-related diseases such as diabetes. With expansion comes higher profits, but at the cost of higher insurance premiums, if ODs can get insurance at all.

Although premiums are still relatively low for most optometrists, they will not remain so for long, insurers say. Optometrists today are a higher risk. There are three reasons, says Elizabeth Murray of St. Paul Insurance Co. in St. Paul, MN, which insures 4,000 ODs throughout the country.

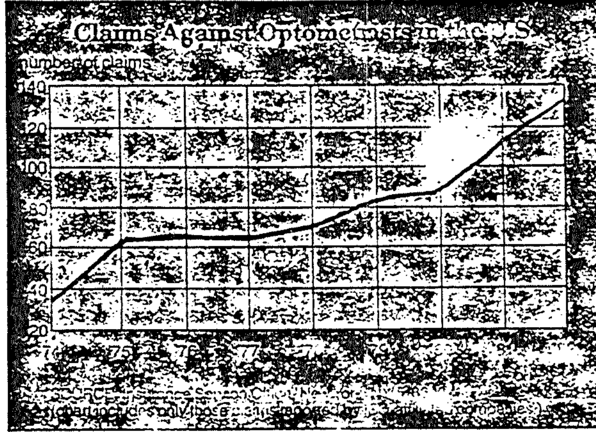
- Forty-eight states currently allow ODs to use drugs to diagnose for diseases, and 11 allow ODs to prescribe therapeutic drugs. As a result, any error made by the OD becomes much more serious in nature. "The claims we see for ODs are similar to the ones we usually see for ophthalmologists," Murray says.
- Negative publicity surrounding extended-wear contact lenses will prompt more people to sue. About 50% of claims filed today have to do with contact lenses, says Murray, and the numbers may grow as risks associated with extended-wear lenses grow. Insurers, she says, are monitoring CL developments closely.
- Society is more litigious in general. There are more claims being filed; they are more severe in nature; the awards are increasingly larger.

Most optometrists pay between $200 and $400 a year for insurance—still a relatively low-cost item. But ODs are worried, and don't know what to expect next. Jeff Levin, general manager for New Deal Optical in Baltimore, MD, says his premiums went up 50% this year. "We're being lumped in with other MDs," he says. "That's why we're being hit with these increases."

"The OD whose rate went from $350 to $800 is yelling and screaming, but anything under $1,000 is not a whole lot of money," says Gordon Banks, executive director of the American Optometric Association.

"I'm not having a problem yet," says Dr. James Hartzell, owner of Vision Clinic in Des Moines, IA. "But everybody is running scared, looking over their shoulders, waiting for the next shoe to drop."

In Iowa, where since January optometrists have been able to prescribe therapeutic drugs, State Farm Insurance Co. dropped its coverage for all ODs. "They are using the therapeutic law as an excuse, saying ODs are riskier," says Hartzell. "Unless there is some tort reform, optometrists will be pulled into the whole insurance problem."



State Farm Insurance Co. spokesperson David Hurtz confirms that the company did drop its Iowa ODs, as well as other ODs doing business in states that allow them to prescribe therapeutic drugs. "That's like being a physician," he says. "It's too difficult to underwrite."

Other carriers are also balking at underwriting optometric liability coverage. Aetna, of Hartford, CT provided coverage for 6,000 ODs for 20 years, until 1984, when it almost doubled its rates, forcing the AOA to stop endorsing the company's policy. The AOA switched to Chubb and Sons in Short Hills, NJ, but less than a year later, that company dropped the association after the policy offering ceased to be worthwhile, says William Reinertson, director of insurance programs for the AOA.

The ODs dropped by Chubb were eventually picked up by the Great American Insurance Co. of Raleigh, NC, but their premiums were doubled. Premiums charged by Great American are $400 a year for up to $1 million worth of coverage. The AOA endorses Great American, which gives the company's agent, Poe and Associates of Tampa, FL, a large customer base for selling policies. Through the AOA, Poe and Associates provides 6,600 ODs with more economical group coverage, according to Poe Vice President Stan Kloszewski.

"With the endorsement you get a spread of risk," he explains. Laws that would cause premiums to rise in one state are offset by more favorable laws in other states. "Because of its buying power, the AOA has been able to maintain a reasonable rate," he says.

Kloszewski says that the number of claims filed against ODs in recent years is low, although the severity of the claims is rising. In a recent case, an OD accused of misdiagnosing a tumor was ordered to pay $800,000, he says. That was the largest award in recent years. Most contact-lens-associated suits are just "nuisance suits," he says.

The extended-wear issue has not taken a toll on premiums yet, Kloszewski says, but his company is monitoring the situation on a daily basis. A positive trend: More ODs are educating their patients on proper contact lens care, he says, which in the long run could bring rates down.

Optometrists, themselves, are taking a number of steps to reduce their chances of being sued. Compliance agreements are a must, says John Gay, an ophthalmic business consultant and president of Professional Investment Management Services in Peoria, IL. ODs should call patients to check if they are using proper cleaning methods. If they aren't, it should be noted on their charts, so if a case goes to trial, the doctor has written evidence that the patient was not following proper care procedure.

Doctors dispensing eyewear should also check how their patients use glasses. A golfer, for example, should be prescribed safety frames and polycarbonate lenses, and an outdoors enthusiast should be informed about photochromic lenses, says Eugene Keeney, executive vice president of the Optical Manufacturers Association. In the wake of the Glendale suit, manufacturers cannot be too careful, he says. In the Glendale case, a Chrysler Corp. employee was awarded $1.8 million from the Glendale Optical Co. because, according to the court, Glendale failed to warn the worker of the protective advantage of polycarbonate lenses.

Even though suits against manufacturers have been few and far between, association members are being careful. If patients sue, they may sue everyone—the doctor, the manufacturer, and the lab. Doctors, says Keeney, can protect themselves by asking questions and educating patients.

—*Judy Temes*

New Carrera Lens Blocks UV-B Rays

FOR SUN WORSHIPPERS, CARrera has developed a new lens that eliminates unsightly "raccoon" eyes.

The new UV-A Tanning Lens allows UV-A rays to filter through for all-over facial tanning, while blocking out dangerous UV-B rays, infrared rays, and 75% of sunlight.

Carrera, maker of the Porsche sunglasses, developed a special coating that is applied to plano lenses to achieve the effect, says Judith Lam, advertising communications manager for Carrera. Lam would not elaborate on the details of the lens coating, but she said it cannot be used for prescription lenses.

The UV-A lens comes in two colors—gray and violet, and is used on two Carrera models: the Cortez and Santana frames. The sunglasses wholesale for about $25 and cost about $50 retail.

Carrera is still working on obtaining patients for the lens coating, but Lam says the company expects other manufacturers to come out with similar products before a patent is approved.

The lenses are coated at Carrera's manufacturing facilities in Austria. The sunglasses are sold by practitioners, leading department stores, and sporting goods shops. ■

Carrera's new UV-A tanning lens eliminates "raccoon" eyes—white circles left by sunglasses which block out both UV-A and UV-B rays.

9-2

13. COMMONLY WRITTEN SUPPLEMENTAL COVERAGES

(See Coverage and Forms section for description.)

A. Money and Securities

B. Employee Dishonesty

C. Boiler and Machinery

D. Umbrella Liability

E. Malpractice, Professional Liability, or Errors and Omissions

(1) Opticians' Professional

★ (2) Optometrists' Professional. This coverage is not written by State Farm in Florida, Indiana, Iowa, North Carolina, South Carolina, Virginia, or West Virginia.

(3) Veterinarians' Professional

(4) Other Malpractice, Professional Liability, or Errors and Omissions coverages are not written by State Farm.

★ F. Personal Injury. Coverage is not written by State Farm for: Advertising Agencies, Publishers, Broadcasters (Radio or T.V.), Finance Companies, Employment Agencies, Labor Unions, Politicians, Adjusters, Arson Investigators, Celebrities or Controversial Public Figures, Family Marriage Counselors, Psychologists and Attorneys.

G. Hired Auto Liability

H. Inland Marine

(1) Exterior Signs

(2) Valuable Papers and Records

(3) Accounts Receivable

(4) Radium Floater

(5) Miscellaneous Articles Floater (portable surveyors and scientific instruments)

(6) Veterinarians' Floater

(11) Garagekeeper [illegible]egal Liability — This coverage is comm[illegible] written for risks that have temporary custody of vehicles belonging to customers or clients, i.e., auto service or attendant parking. The basic underwriting considerations are:

a. Proper supervision of employees who drive or park customers' cars.

b. Protection against loss by theft by keeping vehicles locked when parked.

(12) Personal Injury — Personal Injury is optional under a general liability policy or under the SMP program. It is included in our Apartment, Businessowners and Office packages. While any one of the three coverage groups may be written separately, it is recommended that all three groups be written. The Regional Office underwriter may require the insured's participation (similar to deductible) on certain types of risks, i.e., motels, mercantiles, etc. The Class Standard page or Special Underwriting Factors will indicate those few classes where this coverage may not be written.

Basic considerations in underwriting Personal Injury are:

a. Favorable loss history.
b. Proper training of employees.

(13) Professional Liability — Professional liability may be written for certain classes as enumerated in the Class Standards section of the manual. This coverage may not be bound unless we are also writing the basic liability coverage for the risk. If such is not the case, provide details on a non-binding application for consideration.

Basic considerations in underwriting Professional Liability are:

a. All specific educational requirements met and continuing education pursued.

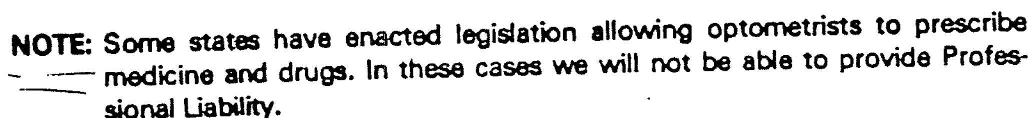
b. Good professional reputation and standing.

c. Quality equipment and products used.

d. All activities carefully reviewed.

e. Favorable loss history.

f. Membership attained in professional societies.


NOTE: Some states have enacted legislation allowing optometrists to prescribe medicine and drugs. In these cases we will not be able to provide Professional Liability.

Testimony of The Kansas Association of Osteopathic Medicine

Bill # S.B. 113
Date 2-13-87

Mr. Chairman and Members of the Senate Public Health Committee.

My name is Harold Riehm and I represent The Kansas Association of Osteopathic Medicine. We appear today in opposition to S.B. 113.

You have heard the issues on this Bill stated over and over, to the point of redundancy. I do not propose to restate those issues, except to speak briefly from the perspective of osteopathic physicians.

KAOM wishes to make these observations:

(1) We take exception with the statement that to oppose the contents of S.B. 113 on substantive medical grounds is only a smokescreen for economic concerns. Hopefully idealism and credibility of medical practitioners is not dead. We think it is not.

(2) We think that the quality of medical care provided by family practice physicians in Kansas is outstanding, and this includes general practice in both the diagnosis and treatment of common eye diseases, the relationship between eye diseases and other bodily disease and ailments, the treatment of eye diseases with drugs where necessary, and the determination of when to refer to specialists in eye care, i.e., doctors of opthamology.

(3) We think the training and schooling of general practitioners regarding the diagnosis and treatment of eye diseases must be placed in the proper context of overall medical schooling. The titles given courses may only partially provide evidence of the extent of exposure to specific subjects. We think the general practitioner is exposed to the subject of diseases of the eye as well as their relationship to other bodily diseases in <u>many</u> curriculum subjects, not just those that a specific reference to the eye in their title.

(4) We believe that most Kansas patients go regularly to a family physician and in case of eye disease would also and should. It is the family physician past and potential reduction to a wide range of drugs based on an overall knowledge of the patient's health. This includes possible reactions to topical drugs used in the treatment of eye disease.

(5) We have heard little if any testimony suggesting a shortage of care for eye disease in Kansas. We suggest there is no such shortage except in those areas in which there is a shortage of general physician care. There rarely is any reason to relax standards set up for the quality of care delivered, but occasionally there may be due to shortage of practitioners. We see no such evidence in this case.

I will be pleased to elaborate on these points as well as respond to questions you may have. Thank you.

SPH&W
2-13-87

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MEETING OF OPHTHALMOLOGY AND OPTOMETRY
State House
With Dr. Jack Walker
Thursday, October 23, 1986, 8:30 A.M. to 9:03 A.M.

Opthalmologists present: Perry Schuetz, Frank Griffith, Dee Bell
Lobbyists: Ron Hein, Rebecca Crenshaw

Optometrists: Terry Hawks, Larry Harris, Peter Brungard, David Crum
Lobbyists: Gary Robbins, Bill Henry

Dr. Walker

Debating and discussing that I had to go to the meeting that I will this morning at 10:00. I have another Public Health and Welfare hearing, intercommittee meeting, trying to deal with some of the things you people are involved with. Taking care of people of Kansas. It's a growing problem. Although we're aware of the problem, we don't have any magic answer. But anyhow, I guess that what came out of the meeting the last time was that you'd meet again. That's progress, I think. At least we agreed to meet again. Again, I want to say to both groups, that I simply agreed to sort of get the room for you and maybe keep you all from feuding too much with each other across the table, but, this is not my meeting. It doesn't have anything to do officially with the Senate Public Health and Welfare Committee, it was just a situation where the Committee felt that if we could get the two groups to sit down together and talk about their issue and see if there was any kind of middle ground that could be reached, it would be in the best interest of everyone concerned, and Roy Ehrlich asked me if I would do that. And I said yes, I would be glad to try. I wanted, as one of our formerpresidents said, I want to make it perfectly clear that I am not opted in favor of one side of the other in this issue, I just feel like in the best interest of both groups that if there is a compromise area, why, it would be helpful; if there's not,

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we go back to the drawing board and both sides can come in in January and do whatever they want to do. I may or may not be here. I plan not to be, but sometimes the best laid plans go wrong, but, I'm guessing right now that I won't be a senator in January. But anyhow, that's where we are and there has been an exchange of letters and proposals and so again, I'm just here to get the thing off the gound and get the lights turned on and get you a room. So have at it. We could be here all day as I understand it. They don't need the room.

Dee Bell

The last time we met, Dr. Walker directed us, or asked about and we asked about, some specific things about the education, the 100 hours, etc. and you all were going to give us back some specific information regarding that. I haven't seen anything. Do you have it with you today?

Gary Robbins

No, I don't. We can get that for you. We're in the process of typing it right now, complete syllabus with _________. We will be glad to provide that with the schedule.

Dee Bell

I appreciate that very much.

Gary Robbins.

Sure.

Dee Bell

The other thing that at that time we discussed was the appropriateness of the bodies to this sort of thing and it was strongly suggested by Ophthalmology that we could, perhaps, involve the University of

Kansas Medical Center with this. I did talk to Dr. Lawwill, as the Department Chairman of the Department of Ophthalmology at K.U., and I understand that Terry Hawks had talked to him also, previous to my talking to him, and he said that the University of Kansas would be very willing to teach a course on the same level as they teach family practice residents, which is what we understood was your goal of education, was to be equivalent to. When we talked about the possible clinical experience, practical experience, he said that he wished there was some way to do that, but their patient load is such that they have enough patients only for their residents, the medical students and the family practice residents and they would have to, in some way, increase the patient loads to give somebody one to one patient contact, and at this time, that was not possible because of their faculty. But he would be more than willing to teach a course which is comparable to what he teaches family practice.

Peter Brungard

He told us he wasn't interested also.

Terry Hawks

That's right.

Peter Brungard

We received some communication from you late last evening, as I understand it, or at the end of the business day and I looked it over this morning, briefly, and I may have missed some things because I did see it a few minutes ago, but I understand from the cursory reading of what you have provided us, it would appear that you are offering some main points, the first of which caught my eye was that we would lose the current use of diagnostic drugs. You would propose

that we would remove non-embedded foreign bodies, use decongestants and antihistamines, after education and testing and that would henceforth make nominations toward our Licensing Board. Ah, and for sure there were some other things that I am overlooking but those seemed to catch my eye first. Are those substantially what was intended, or what is in this proposal?

Frank Griffith

I didn't notice about the loss of diagnostic drugs, where was that at?

Peter Brungard

First page, Under your B which doesn't quite compute but it says "shall not". And then you have listed diagnostic or other procedures.

Frank Griffith

That's coupled with number 4, isn't it? Unless the use of topical pharmeceutical agents for diagnostic or therapeutic purpose by a person licensed to practice Optometry, unless they successfully meet... In other words, that's by your number 4 on page 1? Does that not refer to B? There when he says diagnostic?

Ron Hein

The intent behind the way it was worded was to go back to what was the original concept of the wording and was further recognized, I think in your draft of Senate Bill 651.

Peter Brungard

Oh, okay then.

Ron Hein

Which was that 1 is a broad exclusion of using pharmacological agents and then specifically, you are allowed to use certain pharmacological

agents under certin circumstances. The intent was not to take away diagnostics.

Peter Brungard

So, well, regardless of whether I'm reading right or not, that's not supposed to be that way.

Yeah, okay.

Ron Hein

If that was done because of a drafting error, then it's my fault.

Peter Brungard

Is that all right?

Ron Hein

We thought we were allowing it, also just noted that there was if you will look at the top of 65 1501, that there is a line coming out in little brackets, there is supposed to be an A, subsection A there.

Peter Brungard

Oh, I see.

Ron Hein

Which needs to be there.

Peter Brungard

Okay, gotcha.

Ron Hein

There is no typing there but a bracket.

Peter Brungard

Excellent. Which means, then, that you have mentioned non-embedded foreign bodies and the use of decongestant and antihistamines.

Frank Griffith

Correct.

Peter Brungard

Period.

Both of which are over-the-counter and non-embedded foreign bodies can and will be removed by 99 out of a 100 people you stop in the hall today and say "help me out".

Frank Griffith

Yah, that's not

Peter Brungard

I don't know where this breaks any ground in the present tense.

Frank Griffith

Well, ah, we again followed and discussed your bill after Dr. Walker's discussion of quality assurance and we felt like this would be in the best interest of Kansas citizens as far as protection for their eyesight.

Peter Brungard

Which is to say that your position is that you like things they way they are and that is your proposal?

Frank Griffith

Mmm, not particularly. I think that..

Peter Brungard

Tell me where that's wrong.

Frank Griffith

Okay, you now have it in your ~~law~~ (draft) that you can remove foreign bodies. I still disagree. To me the removal of an embedded foreign body is

surgery. And, even if you want to exclude it, you know, and redefine it, if somebody has a foreign body in their finger and the family doctor takes it out, that's surgery. Now there's no difference with that than one that's stuck in the eye. Now that's my opinion.

Peter Brungard

That's your definition, too.

Frank Griffith

Mm hmm

Peter Brungard

So, that's incredible, that's the definition then, which obviously we aren't going to agree on, I don't think.

Frank Griffith

Correct.

Peter Brungard

What else is new here? Anything, other than what now exists?

Terry Hawks

Except that you want to add to our Board.

Frank Griffith

I think the intent in that was, if you do want to practice medicine, that perhaps, then, just as our Board was expanded under Medical Malpractice Act, that your Board could be expanded too to contain ~~positions.~~ physicians
JHG

Terry Hawks

Would you call an antihistamine and decongestant over the counter, practicing medicine?

Frank Griffith

There are a number that have to have prescriptions; that are not over-the-Counter;

Peter Brungard

Or you could use two drops instead of one.

Frank Griffith

A lot of people think that, but two drops of 2% Pilocarpine does not equal one drop of 4%.

Peter Brungard

Laughter

Also a new drug that we weren't talking about those here. I yet have a problem understanding what you put here for us to talk about. You're saying leave it the way it is and we put some things out that we would like to discuss and some things that if were gonna reach any kind of negotiating agreement, we need to move off of what we have in the present tense. That's what this is about.

Frank Griffith

I think that we have things pretty well straight forward here, that we've discussed it, caucussed and we really feel like what you have proposed is really unacceptable.

David Crum

Did you discuss this with your entire Section, or just among your group, because I think there's a lot of people in your Section who would think we're right on line.

Frank Griffith

Sure, we'll be happy to discuss it, take it back and discuss it with the Section, as I am sure you will with yours.

Peter Brungard

We, our proposal as it now exists, we felt like was pretty reasonable, ah, statement of both in the context of what we talked about last

time and some of the guidelines that Senator Walker put out as moderator, acknowledging as he said, that it's not a formal situation and also in light of some laws that are recently passed in other states, and in line with what we think is a need by the citizenary and what we think we're able to do. Ah, so we have a proposal that I don't think we're necessarily bound to. If we can't agree to something, we're very likely to come up with something that's a little more encompassing than the one we had mailed to you and we want you to understand that. Ah, in addition, we would like to pursue any further negotiations, any meetings of the mind, that are possible. If we can, in fact, reach something, I'm certain it would save all of us a lot of grief and a lot of money. Ah, but that pursuant to those meetings, if we don't get some progress today, are not going to wait in our lobbying for any further meetings. We will meet any time and any place, but if we don't move from where we are now, we certainly not going to wait to begin political activities and begin lobbying.

Frank Griffith

That seems reasonable.

Terry Hawks

Can we clarify this then, as proposal that you gave us as your stance on this issue right now?

Frank Griffith

That's correct

Gary Robbins

It is bottom line, then?

Frank Griffith

Umhuh.

David Crum

You aren't going to budge off of that at all?

Frank Griffith

No. We've had a lot of long discussions on this and that's our feeling. We'll certainly provide the Section members with a copy, poll them and this is what we've come up with at this point in time.

Peter Brungard

Anything else you want to talk about?

Frank Griffith

No. Ron, Rebecca, Dee, Perry?

Perry Schuetz

Well, you know I think that this, from our point of view is morally and ethically correct and if we compromise our views a little bit, you know, we can't probably live with that situation. It's just we've got to do what we think is right for Kansas citizens and I think that's where you guys are coming from and unfortunately we're not coming from the same party line and compromise to me means both parties gain, both parties lose a little bit in what they want. And all I can see is that we're kind of backs against the wall and it's a question "Are you going to lose a little bit or a lot to try to preserve the way things"? You know, I don't see how compromise, it is really a misnomer to use that sort of negotiation. Another thing is that I'd like to mention is that we're compromising the turf of all primary care physicians in Kansas, not just our own turf and I don't even know if it's really

totally correct not to involve the primary care physicians in these negotiations because they're being asked to give up their turf, we are tacitly being asked to compromise their turf without them putting any input into the situation.

David Crum

To rebut that a little bit, oh ah, there are a lot of primary care physicians in this state who would appreciate Optometry being able to support them. Many optometrists have calls on a weekly basis from primary care physicians asking us to remove a foreign body, asking us to treat a conjunctivitis or a problem of this nature, so, there are certainly two sides to that issue.

Perry Schuetz

Well, the president of the family practice section is not as cordial as you indicate as some of the people you talked to, and I think there are two sides to that issue which we haveheard primarily just one side of their point of view. They, meaning the family practice doctors.

Dee Bell

Any other discussion, Frank?

Frank Griffith

No.

Dr. Walker

It would seem like a long trip for a lot of you.

Frank Griffith

Yup.

Dr. Walker

I guess the other alternative is to throw it back into the political arena. You all have the right and privilege to go through the political

process. I think it was the wishes and hope of the Committee that some, and the word compromise, I guess, was the only word we could think of in vocabulary, needs to come back with something which the Senate Committee thought they could deal with, be comfortable with. They didn't want to deal with this, one way or the other. I think a lot of times politicians punt;some politicians do, they punt__________ look at in reasonable terms, not emotional terms, but if you can't, you come back and they'll deal with it.

Perry Schuetz

If the Legislature wants Optometry to practice neuro-surgery, that's the decision they could make. At least we have maintained our values in what we consider right and we haven't compromised it. I think that would be easier for us as officers of the Section, easier for the Section to take than tofeel like we had said something we felt was just a little bit in error to try and, I don't know what, produce something of even graver circumstances from occurring. It's just once you start compromising and just, I don't know, there I'm using a word that I said was being misused, but once we start this process it looks like it's, there's going to be no end in sight.

Dr. Walker

I will report back to Senator Ehrlich that nothing happened.

Dee Bell

Thank you very much Dr. Walker

Gary Robbins

Thank you Dr. Walker.

Dr. Walker

I will see him in about an hour. 10 hard days.

Perry Schuetz

Good luck.

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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	Ophthalmologists
Dr. Pete Brungardt	Dr. Frank Griffith
Dr. David Crum	Dr. Delores Bell
Dr. Larry Harris	Dr. Perry Schuetz
Dr. Terry Hawkes	

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

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. Everything 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.

Senator Walker:

One of the problems last year was somewhat of an emotional thing, was that there was a lot of discussion about who saw the Bill and when. This time, if you have anything in writing, let's get it all out front in January and have it printed and send copies to everybody so that everybody knows what we're talking about.

Larry Harris:

I think the intent we had is come and discuss the issues and the Bill should fall into place once the issues are resolved.

Senator Walker:

If you get a Bill, be sure everybody gets a copy of it. I was hearing late in the Session that some people hadn't even seen the Bill. The Bills are always available for anybody that wants them in the Reviser's office. Well, that's all I can say. I want you to see if you can come to any kind of mutual agreement.

Larry Harris:

I think one of the first issues that we need to resolve is let's identify the actors. Are you speaking for the Section? Do you come prepared to make some decisions? Or is this simply a fact finding thing and we'll get back with you again. I can state upfront that we're here representing the entire Optometric Association, empowered to make some decisions. Cut a deal if you want. I think if it's just a fact finding thing and we'll get back with you in six months or something like that, then it's a moot point. So do you represent the Section and can you make decisions?

Perry Schuetz:

We were elected by the Section and we can represent the Section. I think we have the understanding that if some big deal is going down, we'll probably contact all our membership and tell them what the point is and make sure that there is not a great division within the group.

Peter Brungardt:

By that do you mean something like a phone call? I dimly recall you had a referendum on should this meeting take place in fact. Where you call or write in, that sort of thing.

Terry Hawkes:

So it could be done within a couple of weeks time. What's a legitimate length of time?

Perry Schuetz:

I think two weeks time would be enough, depending on whether we phoned them or wrote them.

Senator Walker:

Let me tell you again, when I wrote to set up this meeting, I said I wanted a small group and I wanted a group that at least could make a tentative decision and do some really serious discussion. I also had to kick your lobbiests out. I apologize for that, but I just thought that it wasn't the proper time for Ron, Jerry Slaughter, and Robbins to be here. I think they can come later if we get down to some serious discussion. I wanted just people who really had a chance to more or less speak for their organizations. I understand that if anything was put down in writing today, you'd probably have to go back and at least talk to your people or they'd throw you all out of office. But at least today, your the group that's going to have to do some serious talking.

David Crum:

Ultimately, do you see us signing off on an agreement?

Senator Walker:

Yes, I think you have to be prepared to come to the Committee next year and tell Roy Erlich that we have agreed that this is a reasonable compromise. The optometrists are the ones that are going to have some options that they are willing to negotiate.

David Crum:

Would it be appropriate to maybe lay out some guidelines on when we're going to have another meeting, and when we would plan to arrive at this final agreement? Would that be a starting place?

Larry Harris:

I think a starting point is to agree that we disagree. If we can point where there is no agreement, then I think we have to be able to say there is no agreement rather than continuing on forever. From a historical point of view, I got out of the Army in 1967, and in 1968 we first broached the subject of diagnostic drugs. That discussion lasted nine years until 1977. And the idea was we agree within the M.D./O.D. Committee, but we have to take it back to our Section. Then the Section would disagree. We had ongoing discussion in the M.D./O.D. Committee from 1968 until 1977. Every time we would get a tentative agreement within the M.D./O.D. Committee, the ploy was to take it back to their Section and then they would always come back and say they couldn't get their Section to agree. I don't feel this discussion

should go that way. Either agree with our common points that we have or say we can't reach an agreement and then we'll go toe to toe. I think the idea that we can't get the Section to agree doesn't work. The crux of the matter is either you speak for the Section or you don't. If you are three individuals here then you don't speak for the Section. If you're the officers of the Section and you can speak with their consensus, then that's an entirely different matter. That's the crux of the matter.

Perry Schuetz:

Are you empowered to make any deals?

Larry Harris:

They told us that whatever comes up, we can make the deal. We have some ideas to discuss--(garbled).

Perry Schuetz:

I can see from your side that no matter what you get, you gain something. From our side of the table, we're asked to give something up, surrender something, and to give mutual equality in certain areas. You're asking us to take a step back so you can take a step forward. In trying to decide on an incentive on our side, what would be this incentive?

Larry Harris:

You just said it--it would actually improve the relationship between ophthalmology and optometry--(garbled).

Perry Schuetz:

If optometrists want to treat glaucoma, then perhaps there should be a mandatory referral clause.

Senator Walker:

Perhaps there could be a cooperative agreement between optometrists and ophthalmologists for treatment and consultation.

Note:

At this point the tape becomes too garbled to completely understand the conversations. This lasts for approximately 8 to 10 minutes and involves discussion regarding the specifics of the optometrists proposed "100" hours of education that would enable them to treat eye disease.

Frank Griffith:

I don't think 100 hours would make optometrists qualified to treat eye disease. I don't think 100 hours would make you guys qualified either.

Larry Harris:

Since you graduated in 1969, we've been taking continuing education for the past 15 years. We take a minimum of 10 hours per year just to get our licenses renewed. We're talking about 15 years minimum.

Perry Schuetz:

We are required to have 50 hours per year to get our medical license renewed. (Garbled).

Peter Brungardt:

Our continuing education has been involved with identifying, diagnosing and treating. that's all there is. You imply that we went to sleep after graduation. (Garbled).

Frank Griffith:

I really think you guys think that 100 hours will do it for you. I'm not buying 100 hours either. I'm not saying Dr. Walker's incorrect, but I think that family physicians do get more training in a lot of aspects. The problem is when I got out of optometry school, I just assumed that the only thing that separated me from an ophthalmologist, because of my optometric indoctrination, was his surgical training. That's incorrect. There is an awful lot of general medical knowledge that you guys will never be exposed to. I don't care how many hours you get. I don't have any doubts about you guys' integrity, I don't think you want to do this just to make more money. (Garbled).

Note:

More discussion about continuing education and who should be the certifying body, but garbled such that an accurate transcription is not possible.

Delores Bell:

Would you identify specifically what you want. We would like to know what we're talking about. If you expect us to negotiate, then we need to know what is on the agenda.

11-19

Peter Brungardt:

In answer to your first question, what do you want to know?

Note:

Garbled discussion between Drs. Bell and Brungardt.

Larry Harris:

Two important points I think need to be mentioned, because the water was muddied last year. We don't want surgery outside of removing foreign bodies. Some of the states have defined that very distinctly, and the way they define it is, "Surgery is expressly prohibited, however, certified optometrists may remove foreign bodies and for the purpose of this section, the removal of foreign matter from the conjunctiva or embedded in the cornea is not considered surgery". That draws a fence around what we can do. We have never had desires to do surgery. We never have. We don't want your surgery.

Perry Schuetz:

Why do the optometrists. . . (garbled). There is only one state with an optometric school that allows them to use therapuetic drugs at this point. What's wrong with the other 14 states?

Larry Harris:

In those states, optometric schools are located in urban areas where ophthalmology is very strong and it's purely political that they don't have therapuetic drugs.

Perry Schuetz:

More discussion but garbled.

David Crum:

Perry, we don't have any grand design to take over ophthalmology. That is not our intent; our intent is deal with the primary care problems in our practice. Hardly a week goes by that I don't have five or six patients in my office that I have to refer, but I'm entirely capable of handling. That's why we're here.

Perry Schutez:

First part garbled. Involves discussion of optometric training; states that 2nd year medical school pharmacology training doesn't allow medical

students to treat disease.

Perry Schuetz:

That's three more years, and those years are dealt with actually using the drugs. You don't count these hours when people are using the drugs and monitoring patients. Seeing Stevens-Johnson syndromes that they may have unfortunately provoked, and learning first hand what it means, not just looking at a textbook. For some reason, that part of the equation gets ignored in this 100 hour business. That's the most important part of the training.

Peter Brungardt:

Understand, the 100 hours has nothing to do with anything, okay. We're talking about basic optometric education--its four years post graduate. It covers what we're talking about; that's reality. We've been in practice, those of us who went to school in Frank's era; we've been in practice all that time. We've been learning, we've been reading, we've been going to courses, we've been observing patients, we've had interchange on a virtually daily basis with you people. Time has not stood still. The 100 hours is to give maybe a fine edge to some of our people, to reassure the public, to reassure the Legislature that diagnosis, the identification, the basic understanding of some conditions as well as the specifics of certain drugs are being brought up to a point assuring quality.

Larry Harris:

Again, I think you're assuming that we're new graduates coming out; we're talking about taking a guy who maybe graduate at Frank's age or Frank's time that has been seeing patients--and according to A. L. Lemoine's own words at the O.D./M.D. committee meeting, that one of the jobs of the consultant ophthalmologist is to send a letter back outlining the diagnosis and therapy so that we know what's going on. And indeed, the ophthalmologists that I refer to on every referral that I send over, I get a letter back with the diagnosis and the therapy. You can bet your life I study those letters when they come back. That's part of my education--the feedback. And like Pete says, we'll see anywhere from four to five of those a week. A lot of the feedback we get is not from ophthalmology. Myxedema, hypothyroidism, you would never see that patient. It goes straight to an internist. Why, because of the peri-orbital edema, should he be bounced off an ophthalmologist when the appropriate referral is straight to either his family physician, his general practicioner, or an internist. You're never going to see him. I had a guy with Myesthenia and ocular ptosis. . .

Perry Schuetz:

If you're solely a referral practice, you won't; but our practices are general ophthalmology practices. We have lots of people that we see.

It just--well, I don't know. Getting back to what you were saying earlier about you're already taking care of a bunch of post-op patients that are on their drugs and you more or less want to codify this. Now I think that form of treating patients was certainly not taught by A. L. Lemoine while I was in the residency. I don't think it is being taught by Ted Lawwill at this point. I think when the residents go through the ophthalmology program, they're taught how to identify a cataract, perform the surgery, and follow the patient until the post-operative period is completed. That's the education the University of Kansas is giving to the graduates in their ophthalmology program right now. It's not set up a cataract mill. It's not up to the referring optometrist and let them manage it, and if they think that their having an adverse drug reaction or the retina is off, then send them back. That's not the sort of educational experience they're getting at K.U. I think that, you know, the fact that you guys are doing what you say you're doing is an aberrancy in our system. The Academy doesn't like ophthalmology practiced in that form. The people that do that are not the guiding light of the Ophthalmology Section. They are a handful of individuals that are kind of a thorn in everybody's side.

David Crum:

There's a minimal amount of that going on. I don't know of any situations in which optometrists are following patients immediately post-op.

Peter Brungardt:

Let Perry get to the end of his statement. I'm not sure what he's saying to me.

Perry Schuetz:

I think I'm at the end of my statement. I'm saying that those people that perform sort of practice. In the first place, those are the ones that got us into trouble with Claude Pepper's committee in the last session. Those are the ones HCFA are using to ram a bunch of stuff down our throats right now. Those are certainly not the kind of people that we extol as being the models of the way ophthalmology should be practiced. When I hear you all talking, I keep thinking you don't want surgery, you want us to do surgery. Then this other area is sort of a mutual area somehow. That's not the way it's being trained.

David Crum:

We need to be aware of these kinds of problems because we're dealing with people that don't always have that good of access to the ophthalmologists that did their surgery.

Perry Schuetz:

I understand that.

David Crum:

They come into us with a complication because they can't get to Wichita or to the site to see the surgeon. We have to be able to deal with that.

Larry Harris:

Plus the original thing is where did the patient come from originally. Did he come from optometry or did he come from ophthalmology.

Perry Schuetz:

It probably depends upon what kind of practice you have.

Larry Harris:

Yes, that's true, but a lot of cataracts are identified by optometrists, referred to that ophthalmologist, the ophthalmologist does his surgery, and in a reasonable period of time, the patient is returned. We're not talking about tomorrow or the next day.

Perry Schuetz:

But in a suitable post-operative period.

Peter Brungardt:

It's still the surgeon's judgement. I don't make the phone call.

Larry Harris:

Part of our caring for the patient is feedback from the surgeon.

Peter Brungardt:

It's his procedure, he makes the call when he wants to release the patient.

David Crum:

I do think your off a little bit, Perry, on the point you're trying to make. I don't think they're a handful of optometrists in this state that are following post-op patients until they're off their medications.

Perry Schuetz:

Do you?

David Crum:

No, that's not being done.

Peter Brungardt:

I don't think it matters.

Larry Harris:

But even if it were, in North Carolina, there's an Attorney General's opinion that says it is legal.

Perry Schuetz:

There's also a new change in the Medicare law that says the ophthalmologists doing that are going to have their surgery fee reduced by an appropriate amount.

Larry Harris:

Now we're back to money. We're talking money.

Peter Brungardt:

That's legitimate. If you see them four times, then you should make what the surgeon is.

Larry Harris:

I think it's important that North Carolina asked for an Attorney General's opinion in that "does this fall within the realm of the practice of optometry".

Perry Schuetz:

And they're a state with a drug law.

Larry Harris:

Yes, they're a state with a drug law and they said indeed it is.

Perry Schuetz:

That could be arbitrary. You get up to Virginia and they may not feel the same way.

Peter Brungardt:

HCFA's arbitrary too. Next year it might be different.

Perry Schuetz:

Well, the next issue of the Federal Register may be different.

Larry Harris:

But again going back to your circle and the overlap, again that smacks an awful lot of economics rather than quality of care because we have overlaps with opticians in the fitting of glasses and the fitting of contact lenses. It's one of those things you have to accommodate. There's nothing that creates a monopoly on the same sort of care.

Perry Schuetz:

Do you share the same degree of altruism with the opticians that you wish we would share with you on the turf battles? It seems like everytime we have an M.D./O.D. Committee meeting, we're asked to support you guys on your turf battle with the opticians.

Larry Harris:

You're asked to support yourself.

Perry Schuetz:

Well, not if you have opticians working in your office.

Larry Harris:

I'm not sure I understand what you're saying.

Perry Schuetz:

We have opticians working in our office.

Larry Harris:

The optometry law says and the Healing Arts Law says that if they are

working in your office, there's no problem with doing that. They're under your direct and immediate supervision. But we're talking about a non-licensed group; a non-certified group as opposed to a licensed and certified group.

Perry Schuetz:

Okay, without getting into all the polemics that are involved---

Larry Harris:

I'm just drawing the parallel between the overlaps.

Perry Schuetz:

The opticians are trying to become licensed.

Larry Harris:

We freely admit that's an economic issue. I think that you should freely admit that this also is an economic issue. The fact that we overlap in certain things; there's more than one way of performing a service. It can be done by more than one provider adequately.

Perry Schuetz:

I think that honestly when I went into the profession, I knew what piece of paper I needed in order to allow me to treat the patients. At that time, my present partner, who was practicing ophthalmology in Great Bend, was complaining that the optometrists in the area used to say "don't go to the ophthalmologist--he'll put drops in your eyes". That's when I was starting medical school, and that was the world we lived in back then. I think some of us suffered through the 12 years of college, medical school, and residency. Now we see that we're putting this equivalence in which we view as a lesser degree of training. Maybe by institutions, we don't fully understand because there isn't one in the state of Kansas.

Terry Hawkes:

Are you doing anything differently now than when you graduated? Your paper said you could do this at this time. Have there not been new operations and medications that you can use now that you couldn't use then? You have no boundary on what you can do once you have your medical license. As Pete said before, we have a boundary if something new comes along.

Perry Schuetz:

You have new types of contact lenses or something like that.

Larry Harris:

But it's still fitting contact lenses as opposed to learning phaco-emulsification and radial keratotomy.

Terry Hawkes:

Like learning radial "K" on a weekend in the Bahamas--this type of thing.

Peter Brungardt:

Perry, you're right. I can understand where you're coming from, but--

Perry Schuetz:

I decided I never want to do that operation, having been to one of the courses.

Peter Brungardt:

Life holds no guarantees, I know where you're coming from. You graduated with a virtual monopoly and a license to do whatever you wanted, as long as you wanted. If that's no longer true or maybe is being challenged somewhat. I can appreciate your misgivings. I can't necessarily sympathize with it, but I know what you're saying. That's fine, but our point is simply that nothing is etched in stone. Life doesn't stand still. We're a young profession. Our patient's have needs. Our education warrants a level of doing things differently.

Perry Schuetz:

What is changed in the state of Kansas?

David Crum:

The very point you made about us telling patients not to go to an ophthalmologist, because they use drops to dilate pupils. Most of us dilate pupils now on a virtually routine basis.

Peter Brungardt:

In some measure because the ophthalmologists used to say don't go to an optometrist because he can't see in your eyes. (Laughter).

David Crum:

Our diagnostic capability has been enhanced tremendously just since I've been in practice for 17 years. I agree with Frank. When I came out 17 years ago, I wasn't qualified to use diagnostic drugs. But, I'm certainly qualified at this point and they've enhanced my practice considerably. They've enabled me to provide much better quality of care to my patients.

Peter Brungardt:

Actually, they've enhanced your practices.

Larry Harris:

Our diagnostic things have enhanced your practices.

Perry Schuetz:

I think you're right; I think if we could see the light at the end of the tunnel, all of this would get to the point where we had everybody happy. Except, I feel like happiness is a state of mind that lasts 10 years until some new thing comes down the pike. I could see working together and doing some things and having more mutual get togethers. The threat we have now, is anytime we would do something like that it would possibly be used against us in a new turf battle.

Larry Harris:

What is being used against us today? We agreed in 1977 that we would not go for therapuetic drugs. And this thing is being held as a big dam.

Perry Schuetz:

And you agreed that you'd do it through the M.D./O.D. Committee, which you did not do when this thing hit last year. Instead, you went straight up to the Legislature.

David Crum:

The problem with the diagnostic thing---

Delores Bell:

The state of Wisconsin.

Larry Harris:

The state of Wisconsin? Their Health and Welfare Committee?

Delores Bell:

They reviewed the Act after it had been passed five years to see what it was really doing.

Peter Brungardt:

The point of this is what, Dee?

Delores Bell:

The point is you're going through a lot of time and money. Not only on your own part, but on our part and the Legislature's part we're paying for with tax dollars. What is it benefitting the people? How much benefit are they getting out of it?

Peter Brungardt:

Out of diagnostic drugs?

Delores Bell:

Yes, out of diagnostic drugs. If it's constituting one time per month—one referral.

Peter Brungardt:

I don't buy the "if" in the first place. I don't think that represents a normal condition.

Larry Harris:

Not in Kansas.

Peter Brungardt:

I don't know what tax dollars it saves today on a drug bill we passed 9 years ago. I just don't understand where you're coming from.

How does this relate to therapuetic drugs?

Delores Bell:

It relates to the fact that we're going through the whole thing again. We're back to time and money.

Peter Brungardt:

Well, save time and money Dee, and let's make some agreements and we won't have to go through all this turmoil. I think the Legislature will be here anyway. I'm fairly sure of that.

Delores Bell:

Okay. I want to come back to a bill with you and I'm going to take away your ability to fit contact lenses. Are you going to fight me?

Peter Brungardt:

Lord knows you've tried a few times.

David Crum:

Or ophthalmology has--

Delores Bell:

Or you've tried to take away our ability to fit glasses. It was a law introduced into the Florida Legislature last year.

Peter Brungardt:

That's right. The groups haven't always gotten along.

Perry Schuetz:

What about medical assistants in the state of Kansas? What's the deal on that?

Larry Harris:

They can do vision screenings. They can---

Perry Schuetz:

They can determine a visual acuity?

Larry Harris:

Yes, absolutely, for screening purposes; and they can do it under your supervision.

Perry Schuetz:

According to Lemoine, back in 1976, that was illegal everytime the school nurse took a vision in the state of Kansas.

Larry Harris:

That was part of the update when we did the 1977 law. It also has a physician's assistant's clause in there that allows them under your aegis if you will, to perform some of your acts as long as you take responsibility for their acts. Yes, that was part of the agreement. There was no intent to limit anybody's ability to use assistants.

Perry Schuetz:

But it had been up until that time limited to only optometrists and ophthalmologists to determine a visual acuity.

Peter Brungardt:

Any manner of law doesn't determine an ophthalmologist as distinct from a physician to do anything. In law, aren't you a physician? As is any other physician?

Perry Schuetz:

Yes.

Peter Brungardt:

That's what I thought.

Larry Harris:

And you can do podiatry, or dentistry, or anything else? But there are some limiting factors--

Perry Schuetz:

Well, your hospital might not allow you to do it on the premises if you don't have the credentials.

Larry Harris:

That comes back to some of the other things and why I think it's reasonable to assume that over the years since we've had the diagnostic drug law. That first of all, the malpractice insurance has not climbed all that much and there haven't been that many claims. We're basically conservative souls. There are three limiting factors that are going to limit our behavior. Number one is, I think, how the law is written. However, in your law, there is no limitation--you can do anything you want to. The three other limiting things are number one, your own concept of your ability and/or your limitations. If you're not comfortable with something, then you're probably not going to do it. Number two is the malpractice climate because Jerry Meshow down in Wichita I'm sure would be very happy to leap on any of your little misdeeds and any of my little misdeeds or anybody else. Then, of course in our case, there's the law--the statutory thing. Since you're unlimited, the other two plus your hosptial priviledges as you say--that's the third one. So you've got your ability and your own limitations; number two, the malpractice climate; and number three, within broad limitations as long as it's hospital-based, the hospital rules and regulations and that sort of thing. We have a fourth one, which is our statute of what we can do. We are a limited profession. But because we're limited, we have to come back, and that's what we're doing now. I don't think once in ten years is exactly banging the door down on the Legislature. We're coming back to say let's let it reflect the changes that have come into place. Personally, I graduated in 1962; I personally own one more slit lamp than the entire Illinois College of Optometry had in their whole institution at the time I graduated. Biomicroscopy was not standard procedure in 1962. How many did they have in Houston when they graduated?

David Crum:

It wasn't standard. They were available just for contact lens care.

Larry Harris:

Okay. My routine patient care involves instruments today that weren't even invented at the time I graduated from school. Again, reflecting on the way along. We routinely do fundus photography on everybody, non-mydriatic fundus photography on everybody that walks in the front door. We have an A.O. non-contact tonometer which I will back up with a Goldmann applanation tonometer, which was totally illegal at the time I graduated in 1962. We use an autorefractor with a laser in it, which was not invented. It's only been out in the last five years or so. We use it for screening purposes. A self inflating digital blood pressure screener, for screening purposes. I have a computerized field

screener that I use at different levels. It's a Dicon 2000. None of these things were invented. We routinely use these things. I no more practice optometry today the way I practiced in 1962 anyway. Now where did all of that come along. It came along with continuing education. Yes, it's the same way that---how many phacoemulsifications and how many implants were they doing in 1969 or even for that matter since you graduated. In the learning process, I also was in a unique position to be a consultant for Title 19 from 1969 to 1978. I was there at Blue Cross/Blue Shield reviewing claims both from medicaid patients and also because I was there, they had some Medicare questions. I can personally testify that there were an awful lot of induced glaucomas and a lot of lost corneas and transplants while the quote now "the cataract specialists" were learning how to do that. If you think we're dangerous, go back and look at some of those things that were done while these guys were learning. . .with no limitations at all. No required extra time in order to learn these things. They just decided we found that PMMA is non-irritative and you can implant the things; and while they were doing anterior chamber lenses, they were blocking angles and they were causing corneal endothelial dystrophy and that sort of thing. The number of people that came back that had to have corneal transplants while they were learning this thing. So we havent' really blinded anybody. We haven't really done huge--

Perry Schuetz:

See Larry, that's a caveat for your own desires right now, because you're going to indeed have this same learning experience among yourselves when you go out and start using therapuetic drugs.

Larry Harris:

Are you making the assumption that we are going to do this in a vacuum? Everyone of us has a "P. O.", a primary ophthalmologist that we deal with. Again, going back to that conservative "we ain't gonna hurt nobody" sort of thing. If there's a doubt, you're going to make a phone call.

Peter Brungardt:

If nothing else, it at least gives you a partial answer when you said "what's new?" What's happened in 10 years in Kansas? There's a couple of things that have.

Perry Schuetz:

I know, but it hasn't changed progress quite a ways in spite of this then.

David Crum:

We have really progressed quite a ways in cooperation with you. That's really what it is; this is a cooperative effort. My practice has developed in terms of taking care of my patients through cooperation with the ophthalmologists that I work with.

Larrry Harris:

You bet. We're making phone calls, we're saying. . .you know, there's in calling my ophthalmologist when we first got diagnostic drugs. All the scare about the 10% Neosynephrine, even the 2½%, the narrow angles and that sort of thing. If I've got any doubt about a narrow angle, if I'm concerned about a blood pressure or something like that, before I do it, I'm on the telephone talking to him. He said in most cases, "I note it, I put it down as a contraindication, I look at the risk/benefit thing and then I go ahead and administer the drop. It might be a lower dosage, but I do it and I watch for the side effects". That's in consultation, that's not in a vaccuum. I think most of our guys as I say--we have a "P.O.", a primary ophthalmologist. We also probably have a glaucomologist, a corneologist, and a retinologist. The people we make referrals to, and they may not all be the same guy. I think you guys are coming from the general ophthalmology thing. Probably more encroached upon by what we're proposing to do than that retinologist or the corneologist or the glaucomologist.

Delores Bell:

But how many of those are there in Kansas?

Larry Harris:

Enough, I think---

Delores Bell:

How many do you have?

Larry Harris:

How many what?

Delores Bell:

Primary people who only do retina, only cornea/anterior segment, only glaucoma.

Larry Harris:

I don't think it's a matter of primary, I think it's a matter of "emphasis on".

Peter Brungardt:

You could answer that better than we because they're your colleagues.

Delores Bell:

I think you're only referring to an urban setting. You're certainly not referring to a rural setting.

Larry Harris:

I think it's a problem oriented thing; I think you seek out the best consultant for the particular condition you're looking at. That phone call may be from Topeka to Kansas City, or it may be six blocks across town, or it may be from Topeka to Wichita. It depends upon the particular problem. Right now, my personal opinion is that it's 1972 before the 1973 Roe vs. Wade and we don't do abortions. I'll tell when it becomes 1973 then I'll do it. But I'm not going to do it, and we have leaned on our guys--they won't do it until it's passed.

Peter Brungardt:

So all those antedotes are entertaining, guys. Are we going to talk about the issues or not. We've hashed history for a while, our bad feelings, our good feelings, whatever it is that we've been talking about.

Larry Harris:

I send out all of my foreign bodies and you can bet I'm not sending them all to cornea specialists and stuff like that. They're going to general ophthalmology. I'm sending out my conjunctivitises, any of that kind of stuff, that's going to general ophthalmology right now. That sort of thing will stop when and if this Bill is passed. That's going to stop--a lot of them are. However, my doubtful corneal ulcers are sure as heck going to go to either general ophthalmology or they're going to continue to go to corneal specialists. If there's anything I've got a doubt about, you bet I'm going to be on the phone. It's not that we are cutting off the communication; the wall isn't there to where everything stops. I think you're seeing a lot more threat than what we have on our minds. We're probably drawing a far greater parallel to what we and the family practicioners do than what you do. I have no designs whatsoever on surgery. I have no designs, personally, on any laser stuff. Except, right now, I have at my command a couple of laser instruments for diagnostic purposes that I want. I would be very loathe to exclude lasers for diagnostic purposes, such as a Lous Mark Viscometer.

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 Brad Prokop 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 the 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).

Larry Harris:

Recently I had a patient come in on a Friday afternoon with an embedded foreign body and I had to make five phone calls before I could get somebody that would take the embedded foreign body out, complete with rust ring.

Perry Schuetz:

Is that what you want to take care of? Is that one of the cards?

Larry Harris:

The foreign body? Yes--

Peter Brungardt:

You don't want to get back to the agenda, do you?

Perry Schuetz:

Well, I'm trying to understand this.

Larry Harris:

Well, what we're doing is we're talking about that's one of those that I could have very easily handled. I think I could have done some prophylaxis on that corneal ulcer on his way to that corneologist in Kansas City. These are the type of things. I'm looking at primary care. I don't want your marbles. That's what I'm saying.

Perry Schuetz:

But those are my marbles because I'm involved in primary care ophthalmology.

Larry Harris:

Okay, in that standpoint, those are the marbles I want. I don't want all your marbles. I think you ought to keep the ones like your highest level.

Perry Schuetz:

Like our own surgical marbles?

Larry Harris:

I think you ought to practice at your highest level. Just like we ought to practice at our highest level.

David Crum:

I think the point Dr. Walker made is that ophthalmology is moving into other fields. In my area of the state, it is difficult to get a routine conjunctivitis or problem of this nature into an ophthalmologist, because they are moving into other areas. They're moving into cataract surgery only, or retinal specialties, or glaucoma specialities, or whatever. The primary care problem is more difficult to deal with.

Perry Schuetz:

The people that are doing that are not necessarily, like I say, the ones that we feel are serving their obligation or setting the example for the way we would prefer an ophthalmologist to be in Kansas.

David Crum:

Times are changing though. They're providing better care.

Peter Brungardt:

Even without the practical pragmatic problems, if it's a patient who's under my care and it's a problem I can handle with the knowledge I have, then I should render the care.

Perry Schuetz:

And if it screws up, then you should be able to defend yourself.

Larry Harris:

Absolutely. We're not asking for anything; we expect to be held to the same standard of care for that sort of thing that we do, as anybody else. Again, it goes back to what are the limiting factors. One is your sense of your own limitations, what you can do. I get the sense that you feel we're overstepping that. But by the same token, it's a good man who knows his own limitations. And number two is the malpractice climate. Those are two things that go a long way toward keeping us very conservative. And that's another thing that's had over the years. I've been sued once in 18½ years and that's because a guys glasses were three days late and he took me to small claims court because he couldn't get his glasses in time for his vacation. Now, why has this gone 18½ years? Because I'm damn conservative. I'm not going to take any chances with that guy. You're going to see him, because as far as I'm concerned,

I work very hard at never being the last guy to see an eye that goes blind. I work very hard at that. And if it looks to one like we've got any kind of remote possibility of that happening, he's going to go see that specialists one bump up and if he feels it's necessary to send it one more bump up, that's fine.

Perry Scheutz:

You're typical of your group?

Larry Harris:

I think so. I'm a 1962 graduate. I am a grey hair. These guys have far better training than I do. I had five years when I got out.

David Crum:

I think our malpractice history pretty well speaks for that. We haven't had significant increases in our malpractice.

Perry Scheutz:

You haven't had any of the risks that you are asking for.

Daid Crum:

We have had exposure to considerable risk. We are seeing patients frequently with retinal detachments, intraocular tumors. That's risk--glaucoma, but we're picking those problems up and referring them on. So we've had plenty of the exposure, but I think we dealt with that effectively. Obviously, there haven't been a lot of malpractice suits in Kansas and our premiums reflect that.

Delores Bell:

May I ask a question then? In the states then that have passed this Bill, they have more insurance companies that now refuse to write your insurance than we do.

Peter Brungardt:

That doesn't say anything for Kansas. That shows how she shifts around. That's bullshit and you know it.

Larry Harris:

They're doing it for everything. They're also refusing to write business insurance. It's part of the whole problem.

Delores Bell:

But it's specifically in relationship to this Bill that State Farm specifically wrote out their rider for optometrists in Iowa.

Peter Brungardt:

That's news to me.

Delores Bell:

Would you like to have the information?

Peter Brungardt:

Not very much, but I'll be glad to look at it.

Delores Bell:

It's also been documented in one of your magazines very recently that the malpractice rate has gone up at least 50 to 75 percent in those states. The percentage of suits filed against optometrists. I admit that your premiums are very low, between $200 to $400 or whatever it is, and they have gone up twice in the state of Kansas. Very recently, as Terry told me last year.

Larry Harris:

But so has all insurance gone up. Joyland out here who is the entertainment thing, had their insurance doubled.

Frank Griffith:

In five years, tell me what your premiums are. I'll guarantee you they will go up.

David Crum:

West Virginia has had a number of years experience and their premiums haven't gone up.

Larry Harris:

The point is, we're willing to take the chance. We're willing to take the same chance as anybody else who does that service.

Perry Schuetz:

Is it going to be required that all your members take this training?

Larry Harris:

Those that are certified, you bet.

Perry Schuetz:

Is it going to be required that they all be certified?

Peter Brungardt:

No.

Larry Harris:

No. Is it required that everyone take a subspeciality? I can see for quite some time, there's no grandfather clause whatsoever. However, the guy who has 2 years left before he retires should not be required to do this. There's going to be a transition time. But after the date of that thing, everybody will be required to take those types of post-graduate courses, all the new people will have to have it--yes.

Frank Griffith:

So will the new people then by the good graces of their recent degree then meet this 100 hours of continuing education?

Peter Brungardt:

The new graduates will be tested by our licensing board and they will be licensed to practice optometry as is written here in the law.

Perry Schuetz:

Would you be offended to have physicians on your Board to oversee that part of the testing?

Larry Harris:

From an advisor's standpoint?

Peter Brungardt:

From a testing standpoint?

Perry Schuetz:

No, on the Board.

Larr Harris:

Of course we would be offended.

Peter Brungardt:

We have a licensure Board and you have for purposes of testing those are different issues as I understand it.

Perry Schuetz:

We have the Healing Arts Board.

Larry Harris:

Yes, we would be offended to have a man on the Board for disciplinary purposes and that sort of thing.

Perry Schuetz:

How about for quality control?

Larry Harris:

For testing purposes, yes.

David Crum:

We would be willing to have an ophthalmologist consult on the examination and testing process. But not serve on the Board itself.

Larry Harris:

We would welcome somebody in an advisory capacity to help administer that test. To make sure that we are indeed qualified to do the things we're asking to do.

Frank Griffith:

Okay, so what does the 100 hours entail then that everybody's going to take? The 100 hours I don't really understand the specifics on that since we're getting back to the agenda.

Larry Harris:

Do you want a laundry list of the curriculum?

Peter Brungardt:

Do you want an outline? We can give you whatever you want. I alluded to it earlier. I talked to you about the idea that it is to understand some of the underlying functions involved, some of the basic science considerations, some of the diagnosis and treatment of conditions.

Frank Griffith:

Who's teaching that?

Peter Brungardt:

Pennsylvania College of Optometry. It's an accredited course.

Larry Harris:

The pharmacology instructor is Wolfgang Vogel, who is a PhD who teaches at Jefferson Medical School. He's a tenured professor. The other lady who taught the other part of the pharmacology--

Peter Brungardt:

Larry, it's an accredited institution with hours that are legit. These things are all certified and all that sort of thing. Any other questions?

Frank Griffith:

So that's the 100 hours of classroom activity, then what?

David Crum:

There's a clinical program.

Frank Griffith:

That's what I'm getting at. What's the clinical program?

Peter Brungardt:

Oh, then ask the question Frank. If you want to know, ask.

Frank Griffith:

Well, okay. There's the 100 hours. Is this clinical stuff within the 100 hours?

Peter Brungardt:

No, it would be in addition.

Frank Griffith:

Okay, where's that in here? In the Bill.

Peter Brungardt:

Where's anything in the Bill?

Larry Harris:

There's nothing in the Bill beacuse that Bill is history. We're talking issues.

Perry Schuetz:

So we don't have the Bill we're talking about infront of us?

Larry Harris:

No, we said that up front we were here to talk issues and which time should fall into place.

Frank Griffith:

Okay, so now the practical aspects of it. What are they?

David Crum:

The clinical part? There's a techniques clinical that involves procedural techniques for removing foreign bodies.

Frank Griffith:

Who gives that? Pennsylvania College of Optometry?

David Crum:

Yes.

Frank Griffith:

Are they allowed? I didn't think they even had therapuetics in Pennsylvania.

David Crum:

They utilize therapuetics in school the same way we used diagnostics on a limited extend, Frank, when we were in optometry school.

Larry Harris:

Under standing orders.

David Crum:

But of course, to a much greater extent now. We used diagnostics in Texas in optometry school when there was certainly no diagnostic law.

Frank Griffith:

It was illegal, but we used them.

Perry Schuetz:

Did you have an ophthalmologist around?

11-45

David Crum:

At that time we didn't, but there is now.

Larry Harris:

It's the same way. They have ophthalmologists on their staff in Pennsylvania, with standing orders, there's a protocol.

Frank Griffith:

So you guys go to Pennsylvania?

Peter Brungardt:

We could, but in this instance, they come here.

Frank Griffith:

Okay. How many patients are you going to see? What is it, just slides or do you go in and slit lamp patients?

Peter Brungardt:

It's a little of both and we'll have probably some follow-up practical education and we haven't clearly defined yet either that will involve some patients. The point about patients obviously is that's what we do. That's how we spend our time.

Frank Griffith:

As long as your supervised, yes; just looking--

Perry Schuetz:

Do you have rabbits and you shoot foreign bodies in their eyes and take them out? How do you actually get the hands on experience?

Peter Brungardt:

I'm sure you can do that.

David Crum:

We are going to have eyes that we are going to remove foreign bodies.

Larry Harris:

They won't be rabits. They'll be pigs and cows. That's part of the techniques lab.

Perry Schuetz:

And then you go home and start doing them.

Frank Griffith:

Right now in Kansas, the citizens are guaranteed that their eye disease is going to be treated by a physician; you've already said that the level of competency will be the same. So I'm just trying to specifically see what you're going to do to get your level of competency to the same as the physician's.

Peter Brungardt:

Jack's given you the lowest common denominator in his opinion, and he should have some insight.

Larry Harris:

We're spending a lot more than a month and again going back and tipping the hat to the idea of the basic science and the things leading to that month.

Perry Schuetz:

Are you talking about the lowest common denominator as being the residents in the Family Practice Program? What denominator are we talking about?

Peter Brungardt:

Frank said that the citizens of Kansas are guaranteed that any eye condition they have will be treated by a physician. I said fine, I'll buy that.

Larry Harris:

At which time we're talking about the general practitioner, the family practitioner.

Peter Brungardt:

So from a legal standpoint, we need to exceed that standard by all means.

Perry Schuetz:

Much of the thrust of optometric training is taking care of a healthy eye, isn't it.

Larry Harris:

Most of the thrust today, when that patient sits down in that chair, is your first, foremost and primary job to identify that pathological from that nonpathological eye.

David Crum:

And they're seeing a lot of diseased eyes in optometric training now.

Larry Harris:

That's your first job. After that, then if you've determined that it's a refractive problem or a contact lens problem, then you proceed that way. If it is determined that it is a pathological eye, then you've got another set of options open to you, ranging from watchful waiting, immediate referral, to treatment. That's the other path and that's the one you seem to be forgetting. The first job is to separate that healthy from that unhealthy eye and then to make your decisions.

Perry Schuetz:

I want to make the point that when Jack's residents are over in the eye clinic at KU, they're seeing 100 percent pathology. People don't present down there because they've got a normal healthy eye and they wanted to swap a contact lens. I wouldn't denigrate the sort of experiences those guys are having even though they just have one month doing it; it's exclusively pathology.

David Crum:

Do you have any idea how many diseased eyes we've seen in practice? Or how many diseased eyes I've seen in 17 years of practice? We're dealing with diseased eyes every day.

Peter Brungardt:

Optometric education has the same sort of opportunities. They deal with hospitals, Veteran's Administration, and other sources of diseased

eyes in cooperation with ophthalmology. As you mentioned earlier in allusion to surgical centers on optometric campuses. They certainly have a high degree of exposure to disease processes in the eye, ocular manifestations of systemic disease, and primary ocular disease.

Frank Griffith:

Is this why places like Pennsylvania College of Optometry send them out of state because they don't have exposure to pathology?

Peter Brungardt:

As you said, the political reality is such that--

Frank Griffith:

No, they don't have exposure to pathology.

Peter Brungardt:

No, Pennsylvania does if you've been there as I was. About 95 percent of their patient load is indigent and minority folks and they have some things I'll never see again. I know that.

Larry Harris:

One thing that's greatly different between 1969 and today--

Frank Griffth:

Because the optometric educational process is not in the mainstream of referral; that's what Dr. Lemoine was talking about. Usually, physicians or family doctors refer to an ophthalmologist; and the optometrist, in his training he really doesn't see that many as you guys think you see as far as the diseased eye.

Peter Brungardt:

You're ignoring the number that come from our offices to your offices that don't do see their M.D. when they have a red eye, a hurt eye, or a question about their eye. We see general population.

Senator Walker:

Let me make a comment. It seems like you could document this pretty fast if you need to know how many; you're just throwing vagueness

around. Can't they document it.

Larry Harris:

I have a file that high that I've generated since 1969 or something like that of the referrals and the letters back and that sort of thing. Yes, we can document it. But you're talking about a lot of minutia.

Perry Schuetz:

I don't think we're arguing about your ability to diagnose these things.

Frank Griffith:

I think to do therapuetics, you've got to make the correct diagnosis. That's important. The therapuetics you can maybe look up in a cook-book somewhere. But you'd better make sure you've got the correct diagnosis.

Larry Harris:

Absolutely.

Frank Griffith:

And there's a difference between saying that's a red eye and I'm referring it and saying this is uveitis with secondary glaucoma and this is what I'd do and I'm going to send it to this guy and then he tells you what he does. That's a little different between referring somebody and having the ultimate responsibility of handling it.

David Crum:

A lot of us, Frank, have been treating in consultation already for a number of years on primary problems because that patient can't get to the urban area to obtain care. I've been following those patients and they have them back after they've been on treatment. I monitor them.

Delores Bell:

It's axiomatic for your training, however, a family physician when he sees a patient with a problem, he has to make two decisions. Is it visual or is it medical? He has no way to ascertain the visual requirements, so he sends them to you. You're supposed to tell him whether it's visual or not. That's the only thing he has to go by. Of course, you've been doing that. That's axiomatic from what you do; we are not disagreeing with that at all.

11-50

140 mins

Peter Brungardt:

The Legislators will vote or not for that, Frank, I don't expect you to vote for the Bill. I don't think I'm going to win you over.

Frank Griffith:

That's fine, good, why don't you tell us specifically what you guys are going to do.

Perry Schuetz:

We would like to know what sort of courses you're going to go through. If we don't then we're going to have a fight.

Peter Brungardt:

How are we going to know if your group supports it?

Delores Bell:

If you would give us some specifics so we would know what we're negotiating about.

Frank Griffith:

Obviously, you need more training if you need 100 more hours, that's what you guys have set up. So let's hear the specifics.

Peter Brungart:

No, I say to you that's just assurance; that's just a guarantee to show the legislators and the public and that's to make the issue somewhat moot. So I don't have to entirely claim clinical experience, continuing education, and general knowledge.

Larry Harris:

It's an assurance that it's a heterogenous group out there. There are lots of guys from your and my era that need to be brought up to a certain level. And at the other end of the thing, there are guys who are going to be yawning because it's a review of last year's class. A lot of them that are doing that. But it is an assurance that us old turkeys are going to be brought up to that level.

Frank Griffith:

That's what I don't understand; well, what's the specifics? You've got your 100 hours of courses from Pennsylvania and then now what about the clinical stuff you're going to do?

David Crum:

We're going to have clinical education with patients' approximately 35 hours of clinical training;

Peter Brungardt:

You know, gee guys, there might be a certain element of gamesmanship that anything we give you is just numbers to run out of here and have fun with.

Delores Bell:

You have the numbers for our education.

Perry Schuetz:

I think we're speaking honestly with each other. I don't think there's any deceit in that.

Peter Brungardt:

No, I'm sure we wouldn't do anything surreptitiously; just try to get some numbers to throw around and make hay with.

Perry Schuetz:

Well, if we want to sell your idea to the rest of our number; we need to know what we're talking about.

Sen. Walker:

Can you be more specific about what you plan to do in the way of upgrading your continuing education?

Perry Schuetz:

Do you want the university of Kansas to generate the program over there and let you pass it or fail it?

Larry Harris:

A program will be generated using State Ophthal mologists, let's put it that way. There will be Kansas ophthalmologists involved.

Perry Schuetz:

Why couldn't it be done through an institution like the university of Kansas?

David Crum:

If you guys would come forward and give us that opportunity we would look at it. That would be great. What we want to do is develop our educational program in cooperation with Kansas ophthalmology.

Larry Harris:

We have welcomed that and in 1972--

Perry Schuetz:

If this is a person you're sending all your referrals to is the one that's giving you your course, I don't think you're going to flunk it; even if you deserve to. I don't think you'd flunk it.

Larry Harris:

This is not a person but persons. Several persons.

Perry Schuetz:

Well, make it plural then, several persons you're referring heavily to them, and there's a vested economic interest in it. I think everybody's going to catagorically pass that and everybody's going to get a seal of approval whether they deserve it or not.

David Crum:

Do you think your section would come forward and offer us a clinical education program?

Delores Bell:

I don't think the Section has anything to do with that. All of our educational things in this state are regulated by the state and it should be continued to be regulated by the state.

Perry Schuetz:

I think the state of Kansas could figure out something that would be more of a guarantee for the public than just something you cook up and have some individuals come in and set it up.

Larry Harris:

Okay, but who in the state of Kansas regulates that?

Delores Bell:

All of our education through the state of Kansas is regulated by the University of Kansas Medical Center. If we don't come up to their requirements, we don't go anywhere.

Larry Harris:

How did they arrive at their criteria? Is this a state Law? Is this mandated? Is it vested by a legislative authority? How did they arrive at what you have to do?

Delores Bell:

The Board of Regents then empowers each school to set up the criteria. They then review them and they have to be approved. I'm sure you're well aware that you don't do much in ophthalmology unless you're either Board eligible or Board certified. All that criteria is worked out through the AUP organization as well as the Academy and through the state school which has been from the state given the right to determine what those qualifications are.

David Crum:

We have the same mechanism here in Kansas through our state Board of Examiners. They will determine what is required of us to use these drugs.

Larry Harris:

That's also given by legislative permit.

Delores Bell:

And you have done a magnificant job in the past. But now you're talking about wanting to be physicians.

Larry Harris:

Not at all, not at all.

Delores Bell:

You're going to diagnose and treat disease. Now what is that called?

Peter Brungardt:

It's called full scope optometry.

Delores Bell:

It's called practicing medicine.

Larry Harris:

The question is who owns what marbles.

Delores Bell:

No, it isn't. It's called--

Perry Schuetz:

What's in the best interests of the people of the state of Kansas who are receiving this health care.

Larry Harris:

There's a healthy amount of difference of opinion on what constitutes a threat.

Perry Schuetz:

For most of us here in Kansas, we've gone through an institution that Kansas funds, supports, and controls through the Kansas Legislature and the Board of Regents.

David Crum:

They support our optometry schools. The Legislature has a seat purchase plan for optometric education.

Larry Harris:

So they're also doing the same thing for us.

Perry Schuetz:

Well, they're sending a grant to pay for the funding of Kansas residents when they go to optometry school.

Larry Harris:

Because there is no in state institution. But they're doing exactly the same sort of funding to ensure that type of manpower is available to the citizens of the state of Kansas.

David Crum:

We have the same safeguards in our educational system that you have in yours.

Perry Schuetz:

I don't know, this sounds like something drawn up in the backroom, getting a few people from around the state that apparently you have some sort of prior business relationship with.

Frank Griffith:

Well, could we just agree then that you guys would have something specific on the continuing education for quality assurance?

Senator Walker:

Yes, I think that's what you would have to do. I agree that it has to be somebody that's not suspect. If some arrangement isn't suspect, I would first of all ask KU Ophthalmology Department to design what they consider to be a reasonable training program. I don't know whether it has to be physically there, but they could design the content, what you have to do in their opinion. You have to see 300 patients with glaucoma or you have to see 300 patients with this or that.

Perry Schuetz:

If we are going to be equal in this area, they can tell you what people are doing in that area in that institution in order to get this level.

Larry Harris:

The question is what level?

Senator Walker:

It must be reasonable.

Larry Harris:

Are we trying to make ophthalmologists out of us or are we trying to bring us up to the level of family practitioners?

Perry Schuetz:

You should be at least at the level of the family practice residents.

Senator Walker:

We have a curriculum that I think they could use.

Perry Schuetz:

You want to put yourself in the role of the family doctor up to this point.

Senator Walker:

We have no limitations. I could do cataract surgery if I felt qualified.

Perry Schuetz:

The family doctor should be threatened over the turf battle because in one regard, it sounds like turf that had previously belonged to Kansas family practice physicians, or maybe our turf, I don't know. I don't know who the turf battle is with. I think we can find out what sort of requirements those people had to pass in the ophthalmology area to get their degree.

Senator Walker:

I think it could be done and I think they're reasonable enough that they wouldn't try to do you in by making the National Board of Ophthalmology your test. That would be a little unreasonable. We've set down with them through the years with Lemoine and with Lawwill and said what do you think the primary doc needs to know about ophthalmology to go out and practice in Oswego, Kansas. They've said to us "you need to make the diagnosis for the 4 or 5 common had eye problems. You need to know how to remove a foreign body, you need to identify children with ocular problems when they are born. And you need to know what to do about them in terms of referral". I think that kind of program could be designed. And where it takes place, there are three family practice residency programs in Wichita. I'm sure they have some access to training in Wichita and certainly we have one in Kansas City. That ought to give you two places to do something. I would think you have to come back with some kind of basic educational plan that's going to satisfy everybody. Where, when, how, and what it is going to contain.

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Perry Schuetz:

I think the people doing it shouldn't have a vested interest in referrals.

Senator Walker:

That would be very suspect if that was the case.

Peter Brungardt:

That's also impossible.

Larry Harris:

It's impossible. Everybody here receives referrals from the optometrists.

Peter Brungardt:

Don't you refer to people you learned from if they're still on staff wherever you went for your training?

Larry Harris:

There's no way that we could have ophthalmologists that we do not refer to, because one of the first things we heard last year is that you're going to bring some foreign jake-leg out of Nevada that's going to come in and give you a three hour course and suddenly you're qualified. So we say no. We want local people and indeed we have local people that have agreed to do this.

David Crum:

They have very high qualifications.

Perry Schuetz:

I think we should have University people that are educators, that's been their career choice. They haven't been out in private practice and they aren't entrepreneurs.

Peter Brungardt:

There's some practical problems here too, that puts us in University politics.

Larry Harris:

From which we've been traditionally excluded.

Peter Brungardt:

We don't choose to play.

Perry Schuetz:

What's wrong with that. You would have a meaningful, indisputable--

David Crum:

Education level.

Perry Schuetz:

If they conferred something on you from the University of Kansas or whatever, you would have training that would be impeccable. I would think that no one in the state would question it if you go down to, I don't know where, to be specific. If you just get a certain group of individuals that may not be held in the highest esteem by the Ophthalmology Section and they're going to put a course on for you someplace to get this all taken care of. I think that's going to cause more problems than it's going to solve.

Peter Brungardt:

A couple of points Perry, one is that's a wonderful statement that you made but it does ignore some practical realities of optometry being somewhat out of the mainstream of a medical institution. There are some political implications there which we are not really fond of; two, I'm not sure who appointed the Ophthalmology Section or its judges of who is respected and who has impeccable qualifications. You're a group, a club, a political association. Your organization--

Perry Schuetz:

Are you impuning the credentials of the University of Kansas?

Frank Griffith:

The KU Med Center is a degree granting institution.

Peter Brungardt:

That's a matter of record.

Delores Bell:

Okay, but the state has to come forward and accept what you're stating. Politics has to be the ultimate goal. That's why you're here. In answer to a Legislative mandate.

Larry Harris:

Going back to your original question of why do those schools not have drug laws, the very simple fact is that everyone of them is located in a population center. You know and I know that ophthalmologists are routinely distributed around population centers. If you look at the state of Kansas and look at the numbers of ophthalmologists, except now the population centers are full and they're pouring over into the outback if you will. Most population centers are jam packed full of ophthalmologists. Therefore, the political climate there, the overpowering political climate around these population centers is through ophthalmology. That is one of the real realities as to why those schools do not have therapuetic drug laws. Because of the strong overpowering effect of ophthalmology in population centers.

Perry Schuetz:

If you can bear with us a few more years, we'll have ophthalmologists out in western Kansas and you guys won't have to worry about rural access.

Larry Harris:

According to Al Lemoine's things, those are practicing 85% optometry.

Peter Brungardt:

The practical problem is only part of our concern. We also feel that we should be rendering this care to our patients. It's not exclusively a matter of access. That's part of it.

Larry Harris:

According to Al Lemoine, 85% of it can be treated with lenses, prisms, contact lenses, and low vision aids.

Delores Bell:

Which you already do.

Larry Harris:

That's optometry. So when we talk about general ophthalmology, it seems like tax payers' money being wasted. Why go to school 12 years to be able to treat another 5 percent? I think that if you are going to go to school for 12 years, then you should be practicing at that higher 5 percent level and not be doing 95 percent of your time fitting lenses, contact lenses, and low vision aids.

Perry Schuetz:

Now when Al Lemoine explained the curriculum of the ophthalmology program at the testimony last spring, he said that really the surgery, the part that you think is the glamorous end of this, is really 5 or 10 percent of the curriculum. Most of the time you're doing these mundane things because the world is full of a lot of mundane stuff. From time to time, it's possible to screw up things that seem mundane but aren't.

David Crum:

Maybe we need to get down to just what we need in terms of a clinical education program.

Perry Schuetz:

I think that's the best place to start is to see what education--

David Crum:

To perceive what you would feel we need and where we go from there.

Delores Bell:

Dr. Walker may I ask a question before we continue? What did you mean when you were listing 5 points and you mentioned glaucoma? What exactly did you mean?

Sen. Walker:

Well, in the Bill, at least, when we started out preparing the Bill

I think pretty wide open and that included management, treatment, and diagnosis of glaucoma. I said that, well, that will never go. I don't know where it was in the last final Bill but there's always been one of the emotional areas in this state, is glaucoma. I personally don't think that the optometrists should be doing glaucoma without very close cooperation and consultation; ongoing consultation. I guess if I had glaucoma and I lived is Oswego, Kansas, and went to the optometrist and he said, "You've got glaucoma." I would want him to send me immediately to an ophthalmologist for a basic workup, what kind of glaucoma is it, what kind of management are we going to do. Then the patient has to go back to Oswego and live on a day to day basis. I think there could be some kind of a day to day communication between the two parties; there are telphones in Oswego.

Perry Schuetz:

So does that mean they should get glaucoma medications, or does that mean the ophthalmologist will prescribe it and they will follow ---

Sen. Walker:

Out of convenience I would think they ought to be able to provide the medications from the local drug store because the patient has to get the medication somehow.

Perry Schuetz:

We can do that over the telphone; the patients that we see from Ellsworth or something.

Sen. Walker:

I can't bring it down to that fine an issue and maybe you don't want them ordering the medication.

Perry Schuetz:

Well, I don't know.

Larry Harris:

I think you have to break it down; I don't think you can use the large subject of glaucoma when there are the glaucomas. I have absolutely no intent or desire to handle or deal with narrow angle glaucoma on a primary basis other than to refer it out. I don't want an acute glaucoma, I don't want a secondary glaucoma, and if I see it you can bet your life it's going to be referred. I don't want a hemorrhagic glaucoma.

Perry Schuetz:

What kind of glaucoma do you want?

Larry Harris:

Chronic open angle after consultation with an ophthalmologist.

Perry Schuetz:

It broke the ice.

Senator Walker:

I hope so. Again, I like you both, and I think most of the Committee likes you both. I think everybody in the Legislature recognizes the need of the two groups. They're very well respected. You know there's something about ophthalmologists. They have a high degree of respect. Maybe it goes because of Al Lemoine or something. I don't know. Everybody I've ever known in the profession has been very nice--I think there's just something about that field that is a little different. And yet all the optometrists I've ever known--and I opened an office with one when I started practice and I didn't know the difference between an optometrist and an ophthalmologist hardly. We had a very comfortable working relationship. He helped my a lot and I helped him a lot. It was just a nice, compatible working relationship. When we both couldn't do something, we sent it to KU mutually.

Perry Schuetz:

We had a nice relationship when I was in the Army at Ft. Lee. I had a couple of optometrists that I worked with. There were three as a matter of fact.

Senator Walker:

Again, I would tell you this. I will be glad to meet with you although I'm not much help.

Lary Harris:

Well, I think it's important that you hear it though. I think you are quite a big help. You give the Legislative stamp for us to see what works.

Senator walker:

All I can tell you is I think that the Committee does not want to hear this same bunch of arguments next year. They may not want to, but they may have to. That's their job.

Perry Schuetz:

Before you leave, when do you think we should get together again?

Senator Walker:

I'd put that first on it.

Peter Brungardt:

You made a proposal on education at KU as I understood, didn't you?

Delores Bell:

No, we need to know what you are going to do. We can't go to them and say do this. You have to come back and tell us what it is you have planned and then we can go and see what we can do with it. You've got to give us some idea of what you want. Alright, we've got Dr. Walker to identify glaucoma and put it down in nice specific terms. Now we have something to work with.

David Crum:

Wouldn't it be appropriate to try to work through some of these items today while we're all here? Everybody's busy.

Peter Brungardt:

Dee said they had to go talk to their people about antibiotics, steroids, foreign bodies and the elements of glaucoma that we discussed.

Delores Bell:

Then identify antibiotics; are we talking about antibiotics 100 percent?

Senator Walker:

Could you be a little more specific about what antibiotics you're talking about. There are a thousand antibiotics, you know. I'm sure you're only talking about a few. What percentages, strengths. Last year I was trying to get them to say which antibiotics are you talking about--penicillin, bacitracin. Which ones and which strengths? At least getting it down to some pretty specific areas that you need. And then I don't know whether you can write Legislation that says you can only use "X", "X", and "X". They keep changing all the time--the labeling list.

Larry Harris:

The laundry list is a poor way to go.

Senator Walker:

I'm sure you could narrow it.

Larry Harris:

Generic groups, generic groups.

Senator Walker:

The same way with steroids. If you could get a little more specific about steroids. If you could get them down into a little more defined area, I think it would be helpful. Now, don't fight.

David Crum:

Thanks. Appreciate it.

NOTE:

Dr. Walker leaves the room.

Delores Bell:

Now we're talking about antibiotics. Are we talking about formulary antibiotics, are we talking about experimental antibiotics? We're talking about cortisone. Are you specifically saying you're going to treat all things which can be treated with cortisone? Does that mean we're specifically excluding things?

Perry Schuetz:

Topical, subconjunctival, retrobulbar.

Peter Brungardt:

You may at the moment, I think, work upon the assumption we're talking about topical drugs, antibiotics, topical antihistamines. . .

Larry Harris:

And you can certainly rule out injectibles.

Perry Schuetz:

So you're taking exception with what Dr. Walker said.

Peter Brungardt:

Exactly wrong, Perry, and you know it.

Delores Bell:

Alright, state your position exactly and let me write it down so I understand exactly what you're saying. You're saying glaucoma. Are you defining glaucoma?

Peter Brungardt:

Okay, okay, chronic open angle, simple open angle.

Delores Bell:

And then what's the rest of it?

Peter Brungardt:

Treatment and management after consultation with an ophthalmologist.

Perry Schuetz:

What is a consultation supposed to be?

Peter Brungardt:

Do you have a definition, oh, to confirm to outline treatment plan; you tell me why you would need that. I can't imagine.

David Crum:

I think you would call and describe what you've got, the appearance of the disc, maybe send a photograph of the disc, pressure, fields.

Perry Schuetz:

But this isn't a mandatory referral but you must consult.

Larry Harris:

Yes. But you must consult. There's a big difference between consultation and referral. When you refer it's gone. When you consult--

Delores Bell:

Now we're not talking about a telephone consultation. We're talking about a physical consultation and that patient goes and sees the ophthalmologist.

Frank Griffith:

And is examined by him.

Larry Harris:

I don't know.

Peter Burngardt:

I suppose at this point it's acceptable. Go ahead and write it down the way you want to. You've asked me what we're interested in and I'm telling you. I'm not dotting the "i's" on the law right now.

Delores Bell:

Okay. If I came to you and said I would like a couple of million dollars, wouldn't you like to know what I mean by "a couple of million dollars"?

Peter Brungardt:

Yeah, I think I've given you a pretty narrow idea.

Perry Schuetz:

And your treatment of these glaucomas, is that going to be with oral medications, topical medications only, which?

Peter Brungardt:

I spoke of topical medications, for purposes of our discussion at this point.

Larry Harris:

By who, do you mean generic or do you mean specifically?

Delores Bell:

We have to know specifics. You say okay, we're going to teach 100 hours and I want to teach you.

Larry Harris:

No, we're talking about--I don't feel comfortable in light of the pressure that we've seen on some of the ophthalmologists in this state and giving you their names at this stage of the game.

Delores Bell:

We don't need their names.

Larry Harris:

That was my question. If you're talking about them generically, yes. We can give you the type of individual who would be teaching the course. By type of individual, we're talking about an ophthalmologist who is Board certified and a graduate of--you know.

Delores Bell:

Sure, and in what setting is it going to take place? How many patient's are you going to see? Who's going to follow up on it? Who's going to guarantee that you do all that? How many optometrists are we talking about taking the course at the time?

David Crum:

There's 200. It would be broken into a regional type program so you would be seeing patients first hand on the slit lamps, making the diagnosis and treatment regimen.

Perry Schuetz:

I think the state ought to be the one giving this course. I really do. I think we've got a lot of entrepreneurs thrashing around that would love to do something like this. As I tried to tell Dr. Walker in certain terms be predicated on referrals. I think that's an abuse of the system.

Larry Harris:

At the other end of the spectrum, we have a past president of the Section who is on record as opposing the Bill. And tell me he has no biases. Al Lemoine stood up and testified against the Bill in any method or manner in this stage of the game.

Perry Schuetz:

He's done more than any ophthalmologist in the state to offer continuing education to optometrists.

Larry Harris:

For diagnostics that result in referral for differential diagnosis to an ophthalmologist.

Perry Schuetz:

Well, I don't know how long he's going to be in the picture.

Frank Griffith:

Dr. Lemoine's statement as I recall from the Legislative testimony was that he felt that in his opinion at this point in time, that optometrists were not sufficiently exposed to eye pathology to allow them to treat on a clinical basis. Now that was my best recollection.

Perry Schuetz:

In fact, he was showing pathology and lecturing on that topic.

Frank Griffith:

And he was simply bringing out the fact how the optometry students are formed out of various colleges because they don't have the exposure to pathology.

Peter Brungardt:

That's how they're getting it. That's the point.

Lary Harris:

I think that when we look back over the amount of education that has been furnished at our annual congress or education sessions by Kansas Ophthalmologist, yes, material has been presented but it's only been up to a certain point at which time it ended in a referral to an ophthalmologist for definitive diagnosis. At no time has a Kansas ophthalmologist showed any willingness whatsoever to take it to a differential diagnosis stage. Now, we have some outside ophthalmologists that are teaching different diagnosis.

Perry Schuetz:

If it was mandated by the state Legislature that's funding that institution to do it by god, they'd do it. They're the spigot that turns the money on.

David Crum:

Okay, what exactly do you preceive that entailing? How many hours and how would we do it? I think that's what we need to do. We would caucus before we meet again and talk about it. I don't know what we'd do if they totally rejected the idea.

Larry Harris:

That's entirely possible. I have seen over the years, a distinct change in the climate and how welcome we as optometrists have felt at the KU Med Center from the changing of the guard when Lemoine left and Lawwill took over. A big difference, 1972 through 1974, there was a standing invitation for optometrists to visit the ophthalmology section and spend days on end.

David Crum:

Our goal in obtaining local ophthalmologists to participate in this clinical program, our goal motivation is only to obtain the best type clinical training that we can get. We don't care about the referral aspect of it. Our goal is to get education and training. Now some states have had to bring in referral centers and bring in ophthalmologists from other states and set up referral centers. We don't want to do that. We would much prefer to maintain the relationships we already have.

Perry Schuetz:

How many of these people in the state are educators? They hold degrees, they're physicians at institutions, and they educate. That's what they're paid for.

Larry Harris:

They may or may not be good clinicians.

David Crum:

The people we have are--

Perry Schuetz:

Those who trained us were excellent clinicians. I think this question of favoritism and outside forces motivating the process could be eliminated if we could get something like that established.

Peter Brungardt:

We don't necessarily buy that. You're saying one group of folks can't be trusted. We're saying, "gosh, I'm not sure we can't trust the other folks".

Perry Schuetz:

I'm not sure they can't be trusted. I don't even know who they are yet.

Peter Brungardt:

You're free to impune them. Obviously, we don't necessarily trust--

Perry Schuetz:

I don't know that I'm impuning them. I just wonder what their entire motivation is.

Peter Brungardt:

You're certainly casting some dispersions about their motivations.

Perry Schuetz:

I don't think that they're accepting the guidelines of the Academy of Ophthalmology. I think they're out of step with everybody else.

David Crum:

Any of the people we're involved with are providing the finest quality of care you can find.

Perry Schuetz:

But if it's going to be in the state of Kansas and it's set up by an institution that the state funds and provides education to most of the people in the state. I think you'd be miles ahead if something like that could be worked out.

Larry Harris:

I've agreed that we could have had that a long time ago. I'd like to see an optometry school at the KU Med Center. But it's not going to happen.

Perry Schuetz:

I don't know about an optometry school, but some program for validating the credentials that you all want.

Larry Harris:

We have one, it's called the State Board of Examiners in Optometry.

Peter Brungardt:

I think it's a utopian idea. It's a great idea. If they want to do it, I think we'd be very interested.

David Crum:

Yes, bring a proposal back on that and we'd look at it. You bet.

Delores Bell:

I think we need to caucus and talk to each other, okay.

Peter Brungardt:

Do you want to set a meet or wait and see what happens?

Delores Bell:

I think we have to wait for Dr. Walker to tell us when he's available, dont' we. Since he's agreed to continue to be here.

David Crum:

I think we ought to get some type of tentative idea on when we're going to meet.

Perry Schuetz:

I'd like to have notice for a couple of weeks if I could so I could reschedule the office.

Larry Harris:

Two weeks, a month, why don't we tentatively set something up from a month from now?

Delores Bell:

From the middle to the end of October.

Larry Harris:

The middle to the end of October.

Delores Bell:

Good. Thank you all for coming.

The meeting was then adjourned.