MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE
MONTANA STATE SENATE

January 26, 1987

The meeting of the Senate Public Health, Welfare and Safety Committee was called to order by Chairman Dorothy Eck on January 23, 1987, at 1 P.M. in Room 410 of the State Capitol.

ROLL CALL: All members of the committee were present.

CONSIDERATION OF SENATE BILL NO. 138: Senator Tom Hager, District # 48, sponsor of the bill to establish new licensing boards, first explained the necessity for establishing criteria to determine necessity of new boards, stated that in Section 3, Part 2, the Legislative Council will provide an amendment to lengthen the 90-day reporting period, and reviewed other sections of the bill, such as the section for determining if new boards should be established and how the committees would evaluate and report to the legislature on the establishment of new boards or the consolidation of boards. He also stated that the bill provides for an application fee of not more than $6500 per applicant. That fee can now cost up to $40,000.

PROPONENTS: Roger Tippy, Montana Dental Association, stated that this review process should prevent problems in establishing boards, that experience leads to legislation, and that this should set a good precedent.

Bill Leary, Montana Hospital Association, stated that this bill should prevent the proliferation of licensure bills. Through this bill each group will come to the legislature separately and directly, and they should be able to avoid coming to the Hospital Association for prior approval.

Cindy Brown, Helena dietician, stated that the Dieticians Association does not want to add to the bureaucracy and that this bill seems to be the best way for groups to seek licensure.

Tom Harrison, CPA Society, expressed concern over Section 6, Consolidation of Boards. According to this section, one person may propose consolidation of boards and he would like to see a proposal be more broad based. He would like to see an amendment requiring more public input before implementation of this bill.

Roland D.Pratt, Montana Optometric Association, raised the question that if there were internal changes within a board, would that board have to go through the whole procedure of appearing before the committee, etc. He would support an amendment eliminating that from happening, and stated that such an amendment has now been drafted.

Scott Secat, legislative auditor, confirmed that Mr. Pratt was correct in his assumptions, and that amendments have been drafted to make the bill consistent throughout.

DISCUSSION OF SENATE BILL NO. 138: Sen. Himsl: In reference to the $6500, will the boards by charged $6500?
Scott Secat: The audit committee will set the fee for the groups coming to it.
Sen. Himsl: Does consolidation include the $6500 fee?
Scott Secat: Probably not.
Karen Renne: The committee can charge a lesser fee in that case.

Sen. Hager closed by saying that Mr. Secat's problem has already been handled. Since too many boards are licensed now (for example, 19 of 28 are health care related), this bill will facilitate those that need to operate and end those that don't.

CONSIDERATION OF SENATE BILL NO. 170: Sen. Tom Rassmussen, District # 22, testified that the purpose of S.B. 170 is to allow optometrists to administer drugs to treat certain kinds of eye diseases. Page 4, Line 2 describes the ocular treatment for which optometrists would be prescribing drugs; and Page 5, Line 21 describes the criteria for administering drugs, such as the training that optometrists would have to have. Exhibit # 1.

PROPONENTS: Dr. Larry Bonderud, optometrist, Shelby, MT, testified that the change in the current law is needed to increase access to eye care to the public and to contain costs for Montanans receiving primary eye care services. This bill would allow qualified optometrists to treat the eye and surrounding tissue to care for common infections, like pink eye, allergies, routine inflamatory conditions, superficial abrasions, the removal of superficial foreign bodies, such as wood, dust, and metal and non-surgical glaucoma treatment. Because the bill will not allow optometrists to treat non-ocular disease, it doesn't allow the use of non-ocular drugs. The bill also does not allow the "grandfathering" of any currently licensed Montana optometrist to provide therapeutic eye care, nor does it change a person's freedom of choice to choose an eye surgeon or general practitioner for eye care. For people having the common eye conditions described, they must now be referred to other health care practitioners, which is an added cost to Montanans in terms of another doctor's bill, additional travel time and time away from work. Presently, Montana is served by 135 optometrists distributed around the state, while its 40 opthamologists are generally concentrated in Montana's larger cities.

Optometrists providing primary therapeutic eye care can help to control health care costs because they are traditionally less costly; quality of care does not have to be lessened because of the training that optometrists now have. 85 to 95% of eye care treatment is primary care, and the present law requires people with these conditions to consult with a specialist, which is a costly system for Montanans. Optometrists should be allowed to practice at the highest level of their training. Exhibit # 2.

Bruce Coen, Optometrist, Helena, testified that optometrists now have the most extensive training in the treating of eye care. They must also have additional training each year to remain licensed. Thus they are asking to be allowed to provide the care consistent with their training. Optometrists also recieve extensive training in use of appropriate drugs and would like to use them, especially considering that people in other health fields use therapeutic drugs with less or equal training. Optometrists also have an educational background of eight years of college and advanced study. Their study of pharmacology includes more hours than any other health care profession using drugs, clinical training continues through the four years of optometry training plus internships during the fourth year, and they graduate from certified schools and pass national and state board certification. In Montana, only the profession of optometry is denied the use of therapeutic drug treatment. Exhibit # 3.

Bill Simons, optometrist, Helena, MT, stated that in Montana dentists and podiatrists are allowed to use therpeutic drugs in their work far beyond what optometrists are requesting, even though the optometrist's training is far more extensive. Now more that 80% of eye prescriptions for medications must be written by non-opthamologist physicians, who have less training and instrumentation to diagnose and manage eye problems that optometrists. Primary eye treatment should be done by the family practitioner of eye care, the optometrist, and advanced care should be left to the opthamologist. Exhibit # 4.

Doug McBride, optometrist, Billings, testified that the state of West Virginia has permitted optometrists to use therpeutic drugs for ten years; and the courts have found that the privileges have been handled carefully. Optometrists using therapeutic drugs have seen no significant rise in malpractice insurance rates. Exhibit #5.

Paul Kathrein, President of the State Board of Optometry, stated that the Board will guarantee that Montana optometrists will meet the national standard as other states have already done and that there will be no grandfathering of currently practiicing optometrists. The Board will provide for whatever education and clinical training is necessary for the safety of Montanans. For the last ten years Montana optometrists have been using diagnostic drugs that are more toxic than the drugs they are now requesting to use and no complaints have been received by the board. Universities have developed excellent drug courses and extensive clinical training that optometrists now take and will continue to receive training in. If Montana optometrists do not take or pass the required drug courses, they will not practice that part of optometry in Montana. The state board will provide for the necessary and training to ensure that only competent optometrists practice in Montana. Exhibit #6.

Millett Keller, practicing optometrist since 1936, stated that optometry training has gone from an original two-year course to an eight-year course with continuing education and training. The profession has advanced since he began as Montana's now longest practicing optometrist. Education at several of the nation's great universities provide vision care to Americans surpassing any in the world. Ten years ago he took the course for the use of diagnostic drugs, which was tough and comprehensive; he passed and uses the drugs daily in his work. He hopes to take the course in therapeutic drugs, should this bill pass the legislature. There always have been elements opposed to the growth of the optometry profession, but in each instance, the hypothetical arguments have proved to be wrong and the factual results have been in the public interest. Exhibit # 7.

OPPONENTS: Steve Weber, stated that the problem of rural residents to get to an opthamologist is actually solved in two different ways. First, rural residents expect to travel for quality services; and rural residents may also see their family physicians for emergencies, who can then check with the area opthamologist. S.B. 170 conpromises the public safety because an optometrist's education is in visual analysis and they normally look at normal eyes. They deal with the superficial part of the eye. In the treatment of eye inflamations, for example, "pink eye" may have many causes; some may heal without medication, but some may be seriously misdiagnosed.

Dr. Everett Lensink, Opthamologist, Bozeman, stated that while the opthamologists have supported the optometrists using diagnostic drugs, their drug courses really do not make them sufficiently competent to treat diseases of the eye. It can be very difficult to treat some of these diseases because they may be caused from illnesses in different areas of the body. Serious harm can be done to the parient who does not come immediately for proper treatment.

Dr. Richard Bagely, opthamologist, Missoula, stated that the bill may benefit the optometrists rather that the public. There is too much competition in optometry, from chains for example, so they need to move into the disease field to become more economically viable. Exhibit # 8.
A doctor treating eyes needs to know what he is treating and how to treat it. Treating glaucoma is an economic issue because patients must return frequently for treatment. The state may be creating a new medical profession by giving optometrists permission to use all drugs. Optometrists do not have extensive enough clinical experience for that, nor will they be carefully scrutinized enough by the public. The bill authorizes a lesser quality of care than the public now receives, nor would optometrists fall under the Board of Medical Examiners.

Steve Brown, lobbyist, Montana Academy of Opthamology, stated that doctors cannot simply study texts and be competent. The opthamologist has three years of clinical training and will see 3,000-9,000 patients before going into practice, while an optometrist will have one hundred hours of course work without the clinical experience.

Page 4, Lines 1 and 2 place no limitation on what an optometrist can do, so that they could even try to provide treatment for cancer. Another important issue is that there is no requirement to have the course in drug therapy approved by the Board of Medical Examiners. The bill simply provides for approval by the Board of Optometry. Thirty-nine other states have not allowed this type of legislation.

DISCUSSION OF SENATE BILL NO. 170: Sen. Himsl: Are occualr drugs of a special class?
Dr. Younger: No, opthamologists and optometrists use a variety of drugs.
Sen Himsl: Are optometrists qualified for third party payments?
Sen. Rassmussen: Yes, if there are vision care provisions in the insurance plans.
Karen Renne: Provision 37 allows that under Medicare-Medicaid. Title 33 does not allow for state employees.
Bruce Coen: Optometrists will be reimbursed for services by Medicare-Medicaid federally after this year. And, if this legislation is passed, pharmacists can fulfill perscriptions from optometrists.

Sen. Eck: Under current practices, are optometrists working with opthamologists in rural areas?
Steve Weber: Yes, when necessary. And optometrists often work with general practitioners in areas distant from optamologists.

Sen. Meyer: Have the optometrists considered a different bill?
Sen. Rassmussen: Nothing has been slipped in that hasn't been worked on for the past two years.

Sen. Himsl: On Page 4, lines 4 and 5, it refers to a body in the eye. What will you do about objects in the eye?
Dr. Bonderue: We do have some options in rural areas. It is often timespossible for an optometrist or a general practitioner to remove some objects, and as an optometrist, I often get referrals for small objects. For deeply imbedded objects, I refer patients to an eye surgeon, and I still would have to do that. Basically, I would like to treat specific occular diseases and that would call for a more limited listing of drugs, which we would be careful in choosing. Systemic diseases would be treated by a physician.
Dr. Bagely: There is nothing to stop an optometrist from using oral drugs, like cortisone.

Sen. Rassmussen closed by stating that the committee is the forum for many turf battles. Optometrists have been using diagnostic drugs for over ten years and have had no complaints to boards or seen any rises in their malpractice rates, nor have malpractice rates gone up in states that allow optometrists to treat simple eye diseases. In addition, people in rural areas would have the benefit of having routine eye diseases treated locally at less cost. Optometrists, particularly with their equipment, can recognize serious eye diseases such as caner, and would refer these

patients to a specialist. They would hardly dare to do otherwise because of the threat of malpractice suits or cost effectiveness to consumers. Additional letters - Exhibit # 9.

Sen. Hager requested that Karen Renne work on amendments.

The meeting adjourned at 3:00 P.M.

Dorothy Eck

CHAIRMAN

ROLL CALL

Public Health, Welfare and Safety COMMITTEE

50th LEGISLATIVE SESSION -- 1987 Date 1-26-87

NAME	PRESENT	ABSENT	EXCUSED
Dorothy Eck	X		
Bill Norman	X		
Bob Williams	X		
Darryl Meyer	X		
Eleanor Vaughn	X		
Tom Rasmussen	X		
Judy Jacobson	X		
Harry H. "Doc" McLane	X		
Matt Himsl	X		
Tom Hager	X		

Each day attach to minutes.

DATE 1-26-87

COMMITTEE ON Senate Public Health

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One Support	Oppose
J. Salisbury	Self			X
R. Skinner	Self			X
Stan Bambauer	Montana Society of Disp. Opticians			
L. D. McGlynn	M.D. ophthalmologists			X
James [illegible] MD	M.D. Ophth.			X
Allan N Beardsley	MD Ophth			
Emmett R. [illegible]	MD ophth	170		X
Kenneth M Younger	MD - ophthalmology	170		X
Steve Brown	Mt. Acad. of Ophtal.	170		X
William Leary	MHA - Helena	138	✓	
Richard Belgrade	MD - ophth.			✓
[illegible] Ullman	MD OPHTH			
Steve Weber	MD opth-	170		X
Jenny Younger	consumer	170		X
Doug McBride	O.D.	170	X	
D. Kathrein	O.D	170	X	
Bruce Cren	O.D	170	X	
Loren McKerrow MD	MD / ophthalmology	170		X
Brian Zins	Mt. Medical Assn	170		X
Larry Obie	O.D.	170	X	
Doug Safley	O.D.	170	X	
Ramona Jacobson	OD's	170	X	
Roland D Pratt	MT Optometric Assoc	SB170	X	
Larry Bondeud	O.D.	SB170	X	
Bill Simons O.D.	OD	SB170	X	
Larry LaRock O.D.	Optometry	SB 170	X	

(Please leave prepared statement with Secretary)

DATE 1-26-87

COMMITTEE ON State Public Health

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
M. J. Keller	Optometry	170	X	
Jim Zoeller	M.D.A.	170		✓
Bethany A. Peters	R.N. Ophthamology	170		✓
Diane Gray	optometry	170	X	
Kathryn Becker	optometry	170	X	
Judith A Carlson	NASW	138		
Roger Tippy	Montana Dental Assn	138	X	
Mary A. Keller	Optometry	170	X	
Mark Bunt	Optometry	170	X	
[illegible]	[illegible]	170	X	
Jim Burns	Optometry	170	X	
Gerry Mesiem	Optometry	170	X	
Roland W Pratt	MT Optometric Assoc	SB138		✓
Cindy Brown	MT Dietetic Assn	SB138	X	
Richard Hopkins MD	opth.	170		X
Bruce Bellin MD	Onc Radiologist	170		X

(Please leave prepared statement with Secretary)

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 1-26-87
BILL NO. S.B. 170

Therapeutic Eye Care in Montana

The Montana Academy of Ophthalmology

The Montana Medical Association

In virtually every legislative session, optometrists in Montana have proposed some sort of legislation. This year is no exception. Senator Tom Rassmussen, an optometrist, has introduced Bill #170, which would allow optometrists to use drugs for therapy of the eye. We oppose the expansion of optometric practice in this way because optometrists are not qualified to safely perform such services, the proposed "educational courses" designed to teach the necessary skills are vastly inadequate, and expanding optometry into therapy would lead to increased costs to the public.

About Eye Doctors. There are two kinds of "eye doctors," optometrists and ophthalmologists. Here's how they differ:

An **optometrist (O.D.)** is licensed by the Board of Optometry and specializes in determining the need for glasses to restore or improve vision, as well as selling glasses to clients. Optometrists treat vision disturbances with glasses and contact lenses and may also prescribe exercises for muscle imbalances. Optometrists are not Medical Doctors.

An **Ophthalmologist (M.D.)** is licensed by the Board of Medical Examiners to practice medicine and surgery and specializes in all aspects of eye and vision care. The ophthalmologist uses and prescribes medicines, glasses, contact lenses, and performs surgery. Ophthalmologists are Medical Doctors.

It is important to realize that **the difference in educational background and experience between these two types of doctors is enormous.**

	Optometrist,O.D.	Ophthalmologist,M.D.
college:	2-4 years	4 years
Optom. school:	4 years	--
Medical school:	--	4 years
Internship:	0	1 year (in-hospital intensive general medical training)
Residency:	0	3-4 years (specialty training in eye disease and surgery)

During training, an optometrist performs 350-800 examinations, 95% of which are on patients without disease. An ophthalmologist performs 3,000 to 8,000 examinaions, 90% of which are on patients with eye disease.

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The case against optometric therapy. Besides lack of education and experience, there are other important reasons to oppose such legislation.

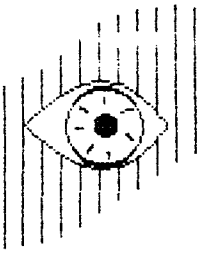
1.) It isn't necessary. In Montana, there is one ophthalmologist per 19,000 people; the recognized average need is one per 25,000. There is an ophthalomolgist in every major Montana city, and few patients are farther than an hour's drive from an ophthalmologist's service. General Medical Doctors routinely prescribe therapy for the eye and are available to all Montanans. There is absolutely no demonstrated deficiency in delivery of therapeutic eye care in Montana, and absolutely no need to expand this privilege to optometrists.

2.) Safety to the public. The possible consequences of erroneous treatment of eye disorders include pain, vision loss, and blindness. In 1985, the Consumer Affairs Committee of the Pennsylvania House of Representatives was "not convinced that even optometrists who have recently attended an optometric college have received sufficient education to be authhorized to use therapeutic drugs solely at their discretion. Neither is the Committee convinced that such an authorization would not have an adverse impact upon the health and safety of eye care patients. . ."

The proposed legislation would enable optometrists to prescribe oral and intravenous antibiotics, cortisone, narcotic pain killers, and cancer chemotherapy. Such practice woud be unwise and unsafe.

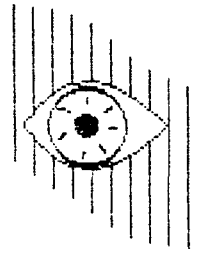
3.) Costs. Every legislator is acutely aware of the importance of the "bottom line". Eye care provided by optometrists is not cheaper! Surveys have found that optometrists generated almost twice as many lens prescriptions from the same number of patients examined by ophthalmologists. Total average payout per patient is greater when patients are seen by optometrists. Will optometrists hold down their fees while taking on increased duties and responsibilities of providing therapy? New exposure by optometrists to malpractice litigation will further increase optometric charges as the cost of increased malpractice coverage is passed on to the public. State Farm Insurance no longer writes malpractice insurance to optometrists in any state where they use therapeutic drugs. The costs of delayed or improper therapy are immeasurable.

There are no short cuts to the provision of safe, quality eye care. A legislator would not consider extending the privilege of flying a 747 to a private pilot just because he or she has obtained additional classroom instruction. Do not extend therapeutic drug use to optometrists. The people of Montana do not need non-medical practitioners prescribing drugs for eye care.



Montana Academy of Ophthalmology

Montana Medical Association



SENATE HEALTH & WELFARE
EXHIBIT NO. 1-26-87
DATE #2
BILL NO. SB 170

TESTIMONY ON SENATE BILL 170

MONDAY, JANUARY 26, 1987

Madame Chairperson and members of the Senate Public Health Committee. My name is Dr. Larry Bonderud. I am a practicing optometrist in Shelby and at the U.S. Public Health Service/Indian Health Service Hospital Clinic in Browning, Montana. I was appointed by Governor Schwinden to serve on the Montana State Health Coordinating Council. Previous to that, I served on the Statewide Health Systems Agency. I presently serve as President of the Montana Optometric Association.

This proposed change in the Montana Optometry Law is needed for two basic reasons. Increased access for the public and cost containment for Montanans receiving primary eye care services.

This bill as proposed would allow qualified optometrists to treat the eye and surrounding tissue to care for common infections, like pink eye, allergies, routine inflamatory conditions, superficial abrasions such as a scratched eye, the removal of superficial foreign bodies, such as wood, dust, and metal and non-surgical glaucoma treatment.

The bill will not allow optometrists to treat non-ocular disease, therefore it does not allow the use of non-ocular drugs. The bill does not allow optometrists to conduct eye surgery, nor does it allow the optometric treatment of cataracts, detached retinas, lazer use, retinal problems, or the removal of penetrating foreign bodies that enter the

eye.

The bill will not allow the "grandfathering" of any currently licensed Montana Optometrist to provide therapeutic eye care.

This bill will in no way changes a persons freedom of choice to be able to choose an eye surgeon or general practitioner for primary eye care.

The majority of Montanans who seek eye and vision care enter the health care delivery system through the profession of optometry. To those people the optometrist is the family eye doctor. For those people who have the common eye conditions that I previously described, it is currently mandatory that they be referred to other health care practitioners. This is unnecessary and it is an added cost to Montanans in terms of another doctor's bill, additional travel time and time away from work.

This needed change in Montana's optometry law would also enhance access for Montanans who frequently seek primary eye care services. Presently, Montana is served by 135 well distributed optometrists. Montana's approximately 40 ophthalmologists are generally concentrated in Montana's, larger cities.

Many consider controlling costs in the health care system the most significant and overriding consideration. Optometrists providing primary, therapeutic eye care can begin to control costs. Optometrists

can provide competition in the eye care field. We know that this is a natural way of controlling the cost escallation suffered in health care. Non-surgical health professionals, such as optometrists, are traditionally less costly for the health care system, both directly and indirectly. However, reducing costs does not mean reducing the quality of care received from primary care professionals.

Primary care is that level of care delivered by "first contact" providers. These are the doctors first contacted by a person in need of health care. They are able to diagnose and treat the great majority of persons they see. It is estimated that 85 to 95 percent of all health care can be classified as primary care.

Secondary-level care providers are those who receive additional specialized training beyond that which is required of primary care providers. An eye surgeon is defined by speciality as a secondary-level care provider.

Eye care continues to be the single area of health care in the United States wherein eye surgeons, are the only trained professionals allowed by law to provide primary level therapeutic service. This adversely affects the cost of such care and more so, the access to such care due to eye surgeons concentrating in Montana's larger cities.

A more poignant need for change in this system is because of the present system which refers patients who have minor conditions to specialists. Presently this is a costly system for Montanans.

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Montana optometrists should be allowed to practice at the highest level of their training.

With the proper training in eye disease management that optometrists now receive, they are certainly ready to serve Montanans' primary eye care needs in a total fashion.

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EXHIBIT NO 2
DATE 1-26-87
BILL NO. SB 170

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BILL NO. SB 170

TESTIMONY ON SENATE BILL 170

MONDAY, JANUARY 26, 1987

Madame Chairperson and members of the Senate Public Health Committee.

I am Bruce Coen. I am presently in private optometric practice in Helena. I am here to speak in favor of Senate Bill 170

Optometric education has expended beyond the framework of current state law. Optometrists are asking to be allowed to provide those expanded services which are consistent with the current scope of our training and education. Optometrists, Podiatrists, Dentists and medical doctors have equivalent undergraduate requirements. Of all students accepted into optometry schools, 80 percent have already received a four-year bachelor's degree. The optometry program is an additional four-years. Studies include optics, optometry, human physiology and anatomy, neurology, microbiology, general and systemic disease processes, systemic pharmacology, ocular anatomy and physiology, ocular disease and pharmacology. Thus the average educational background of an optometrist is 8 years of college and advanced study.

Let me point out that optometric colleges offer an average of 156 hours of pharmacology. This is equal to or greater than all other health care professions presently using therapeutic drugs. In addition, optometric curricula in ocular disease diagnosis and

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treatment is more extensive than any other non-ophthalmological health care program. The courses include detailed training in symptoms, clinical picture, diagnosis, and treatment of eye conditions.

Clinical training begins the first year with procedure clinics and patient care observation. Patient observation and procedural workups continue during the second year. The third and fourth years involves intensive supervised patient examinations, diagnosis, treatment, and management. The average optometry student has over 1000 hours of clinical eye experience, and has 1,500 to 2,000 formal patient presentations. Students are trained under the supervision of a multi-disciplined faculty, which includes ophthalmologists.

In addition to clinical training at the schools and colleges of optometry, fourth year students are required to complete externships in private practice as well as in institutional settings, such as health maintenance organizations, Veteran's Admistration Hospitals, and ophthalmological clinics.

All 15 schools and colleges of optometry are accredited by the same agencies that accredit medical schools.

All optometrists upon completion of their education must then pass a national board certification as well as a state clinical examination before receiving a license to practice optometry. In

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addition, all Montana optometrists are required to attend Board certified education on a yearly basis to maintain licensure.

Among the Montana health professions trained in therapeutic drugs, which includes medicine, denistry, podiatry and optometry, only optometry is denied the use of these drugs.

Montana Optometrists are trained and qualified to deliver treatment programs which require therapeutic drugs. I ask for your support in this legislation so that Montanans can receive the full benefits of current optometric education.

Thank you Madame Chairperson and members of the Senate Public Health Committee

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TESTIMONY ON SENATE BILL 170

MONDAY, JANUARY 26, 1987

Madame Chairperson and members of the Senate Public Health Committee.

My name is Bill Simons. I am a practicing optometrist in Helena, Montana.

I stand before you today in support of Senate Bill 170 for the following reasons.

Numerous comparisons will be made today between optometry and the other professions currently using therapeutic drugs. How does optometry compare to these sister professions? We should first compare optometry to her non-medical counterparts who currently prescribe drugs for treatment. In Montana, podiatrists and dentists are permitted statutorily to use therapeutic drugs far beyond the limits requested by optometry. If we compare their classroom and clinical training to optometrists, we find optometrists equal to or exceed their colleages in drug education and clinical experience.

Dr. David Mann, Professor of Pharmacology at Temple University Dental School compared the dental pharmacology curriculum to the optometric pharmacology curriculum at Pennsylvania College of Optometry.
Dr. Mann found the following and I quote:

"the coverage between the two is remarkably similar with emphasis of areas naturally placed on those aspects of pharmacology which

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the particular specialty demands."

"The optometric presentation goes beyond ours in both drug classes offered and hours involved." Unquote.

The most important comparison today is between the optometrist and the general physician as it relates to the treatment and management of eye disease. Dr. Richard Rashid, a prominent West Virginia ophthalmologist, stated in testimony to the Tennessee legislature that more than 80% of prescriptions for eye medications were written by non-ophthalmologists. When compared to these non-ophthalmologist physicians, optometrists have more training and sophisticated instrumentation to diagnose and manage eye problems.

Because of optometry's intense study in eye disease, drug education and proper instrumentation (of which the general practitioner has very little) it is clear that optometric education and competencies are more extensive than the general physician in the area of diagnosing and treating eye disease.

The true comparisons should be optometry to family practice medicine, dentistry, and podiatry. Unfortunately, the comparison between optometry and ophthalmology clouds the issue.

In closing, let me pose this question: If you developed a sore tooth would you seek care from an Oral Surgeon? Probably not. You would go to a dentist who would look at you first and only if necessary refer you to the oral surgeon, who is a specialist consulted in advanced oral/surgical treatment.

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Comparing the education of a general dentist to an oral surgeon is unrealistic, as it would be in any health care field.

The same is true with primary eye treatment. It should be done by the family practitioner of eyecare, the Optometrist, and leave advanced medical and surgical treatment to the specialist, the Ophthalmologist. Thank you.

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TESTIMONY ON SENATE BILL 170

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Madame Chairperson and members of the Senate Health Committee, my name is Doug McBride and I practice optometry in Billings.

In states where optometry uses theraputic drugs, three documented facts have arisen in support of this proposed legislation.

1. The state of West Virginia has permitted optometrists to use theraputic drugs for 10 years. After a thorough review of this issue by all levels of the West Virginia judicial system, the West Virginia Supreme Court said: "The Court finds no evidence that the optometrist who has chosen to exercise the new priviledges of his profession has failed to exercise them carefully. The legislature in the exercise of its responsibility as parens patriae, or guardian of the people, has chosen to give its people a speedier service in eye examination and treatment by extending the qualifications, capacities, and priviledges of optometrists to prescribe lenses more efficiently and to treat for minor and common infections of the anterior eye and provide for more prompt referrals to skilled ophthalmologists."

2. Malpractice claims and insurance rates are the most impartial and accurate judge of the quality of delivery in health care. Any significant mismanagement of therapeutic drugs by

optometrists would be recognized first by those companies which are carriers of malpractice insurance for optometrists. Ragolia and Company is the major carrier for optometrists in both West Virginia and North Carolina. Based on their experience with the optometric use of therapeutics in these states, they testified to the New Jersey legislature that if they allowed optometrists in New Jersey the same priviledge, that they: "do not anticipate malpractice rate increases resulting from (optometric use of) therapeutic drugs, nor do they expect an adverse claims situation."

Poe and Associates, a large underwriter, found that any difference in malpractice insurance premiums between states is unrelated to therapeutic drug usage.

Current average annual malpractice premiums for optometrists in Montana is $360.00. Wyoming's premium is $300.00 per annum. Whereas, the two states that have used theraputics for a decade, North Carolina and West Virginia, have annual premiums of $300.00 and $360.00 respectively.

3. Documented experience in the use of therapeutic drugs by optometrists in both West Virginia and North Carolina, who have used therapeutic drugs for a decade, attests to the safe and professional use of these drugs.

A study was done by the West Virginia legislature. It was found that therapeutic drug use by optometrists, resulted in no

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adverse affects.

In closing, no state legislature has ever rescinded optometrists priviledge of using diagnostic or therapeutic drugs.

Thank you.

TESTIMONY ON SENATE BILL 170

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Madame Chairperson and members of the Senate Public Health Committee. I am Paul Kathrein, a practicing optometrist from Great Falls, and current President of the State Board of Optometry.

I am here representing the State Board and to present the position of the Board on Senate Bill 170.

Board members are as concerned as you are that if this bill becomes law, the safety and health of the people is protected, and those optometrists who will use therapeutic drugs be thoroughly educated and updated in drug usage, both in the classroom and clinically. They must prove themselves competent by national standards and testing methods. This Board will guarantee that Montana optometrists will meet national standards as other states have already done. There will be no grandfathering of currently practicing optometrists.

This Board can and will provide for whatever education and clinical training is necessary for the safety and benefit of the people of Montana. This was done when Montana optometrists were educated and trained for diagnostic drug use, with excellent results.

Ten years ago, the legislature decided that Montana

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optometrists should be allowed to use drugs for examination and diagnostic purposes. Those diagnostic drugs, Montana Optometrists are presently useing, are considered by pharmocologists to be systemically more toxic than the therapeutic drugs this bill requests. In those ten years there has not been one complaint received by this Board or any other Montana Board concerning misuse, eye damage, or drug malpractice by an optometrist.

Drug courses have been developed by universities that will provide the necessary education and training. These courses are taught by university professors, PhD. pharmacologists, optometrists, and ophthamologists. Clinical training is also available. Extensive hands-on clinical training under direct medical supervision will take place before drug certification will be granted. These courses have been presented in other states that have already updated their optometry laws. These courses and testing sequences have been proven to produce competently trained optometrists.

Preparation for therapeutic drug usage will require considerable time and expense to the individual optometrist. As in the case of diagnostic drugs, not all Montana optometrists will partake and not all of those who did take the course, passed.

In summary, I have tried to show you that the State Board of Optometry can provide for the necessary education and testing required to ensure that only competent optometrists will be

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certified to use these drugs.

AND, that Montana optometrists have proven to be safe users of diagnostic drugs.

AND, twelve other states have already done what Montana optometrists are requesting. It has been successful, safe and beneficial to the citizens of those states.

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TESTIMONY ON SENATE BILL 170

MONDAY, JANUARY 26, 1987

Madame Chairperson and members of the Senate Public Health Committee. My name is Millett Keller. I have practiced optometry in Montana since 1936.

From the original optometry act passed in 1910 to the present day our profession has advanced in education and purpose. Yes, the first optometry law had a grandfather clause exempting all those presently employed in the profession from the law. But none since have been exempt. Every change in the law has required competence and education and testing.

From a two-year college course in the early twenties, to an eight-year course now, what a change! Eighty percent of students entering optometry schools today already have a four-year baccalaureate degree. The average graduating optometrist today has had eight years of college level and advanced study.

As an optometrist who has practiced longer than anyone in Montana, I am extremely proud of my profession, and of my own professional advancement.

What has happened in the intervening decades? Education has been the key. Great universities such as the University of California, the University of Alabama, Ohio State University, Indiana University and others today provide optometric education

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hardly forseen a decade ago, let alone five decades ago. Research in eye and visual problems in these institutions has provided eye care and vision care to Americans surpassing any other vision care worldwide.

Ten years ago, the Montana Legislature granted optometrists the priviledge, with proper education, to use diagnostic eye drugs, believing it was in the public interest. And it was. You were right.

Now, Montana optometrists are asking for the priviledge, with proper education, to use drugs to treat common and routine eye diseases. Other diseases and surgery cases will be referred as now to secondary and tertiary practitioners.

Time and change march on. Progress comes through education and need.

Dramatic changes - yes indeed - and mostly in my lifetime.

Ten years ago, I and some of the other older practitioners took the course for use of diagnostic drugs. It was tough and comprehensive and not all passed. No one was forced to take the course. Each paid for his education. No state aid was involved. I am proud to say I passed! I use these drugs every day in my practice. And I am a better practitioner for it.

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When this bill passes, I intend to take the course. It will be equally tough - maybe tougher than it was ten years ago. Maybe I won't pass this time, but I'll give it a try. No one will be grandfathered, but I will be a better practitioner for it.

However, there are elements which have been opposed to growth and progress in this profession for over 75 years, using the same hypothetical arguments of inadequate optometric education, optometric incompetence, and risk to the public health and safety. There was opposition to licensure in the early 1900's, opposition to university courses and advanced doctor degrees in the 20's, 30's, and 40's, opposition to optometric testing for glaucoma in the 60's, opposition to use of diagnostic eye drugs in the 70's and now opposition to this bill for drug use for disease. In each instance, the hypothetical arguments have proved to be wrong and the factual results have been in the public interest.

PROGRESS - CHANGE - EDUCATION - NEED, all these are embodied in Senate Bill 170. Members of the Committee, I ask for your support for this forward looking legislation.

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EDITORIAL

Tough turf

To the Editor.—It was gratifying to read in your March issue that two thirds of the doctors on your National Panel of Doctors of Optometry are in favor of upgrading optometric qualifications to include minor surgery.

Health care professionals must continuously expand their scope of practice in order to keep pace with evolving technology. When optometrists upgraded their diagnostic abilities, they needed DPAs to perform their duties properly. Similarly, the explosion in contact lens wear has ushered in an era in which anterior segment injuries and diseases are commonplace. Treatment of these conditions is a natural extension of contact lens practice, necessitating the use of therapeutic drugs.

The anterior segment disorders which need minor surgical intervention are rarely sight-threatening; their treatment is certainly within the area of expertise of contemporary optometrists, and few require an ophthalmologist's skills. Optometrists shouldn't let their fear to tread on medicine's turf dissuade them from seeking this natural extension of optometry.—*Vincent P. Lupica, O.D., Bronx, N.Y.*

In the last four months, five states have passed laws that allow optometrists to use therapeutic drugs. This is an amazing accomplishment for optometry. But reading between the lines, I see a disturbing trend: Three of these laws bar optometrists from treating glaucoma.

Getting permission to treat minor infections and emergency conditions such as foreign body and corneal abrasion is an important advancement for optometrists and for patients. In many areas, optometrists are the best educated and best equipped practitioners to handle acute eye problems.

But optometrists can't be satisfied with permission to treat acute problems. Qualified optometrists should also have their state's permission to treat glaucoma patients.

The most important reason is that such laws would be good for patients. Patients with chronic open-angle glaucoma need frequent visits to the eye doctor's office. Glaucoma medications often turn out to be inappropriate or ineffective for the patient, or they lose their effectiveness over time. Patients should not have to travel to the office of an eye surgeon in a distant city to get their medication changed, especially when excellent care is available nearby.

Treating glaucoma, while frustrating, is also good for optometrists. When optometrists treat glaucoma, they can keep more patients under their care, avoiding "one-way referrals." Glaucoma patients make a steady source of income, since they must return frequently for care. And the ability to treat glaucoma further enhances optometry's standing in the health care community.

Clearly, optometry must compromise in order to get any sort of therapeutic bill through a state legislature. But giving up glaucoma treatment is wrong-headed in the long run. Many optometrists are already well educated in the treatment of glaucoma, and pressure will soon mount among doctors who want to use their skills.

When this happens, will optometry be able to return to the legislature to expand the scope of practice? Will it will be able to drum up needed financial and political support for what is, after all, a marginal change? Will it have convincing arguments for legislators? I wonder.

Doctors who have convinced their legislators that optometrists need therapeutic drugs should be commended. But passage of a state law that proscribes treatment of glaucoma is only a partial victory. For the good of patients and the good of optometry, we must fight to treat glaucoma patients.

Stan Herrin
Managing Editor

NEWS REVIEW

SENATE HEALTH & WELFARE
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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 Asept, is having trouble keeping up with it.

Don LoVetere, 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.

Asept'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. ■

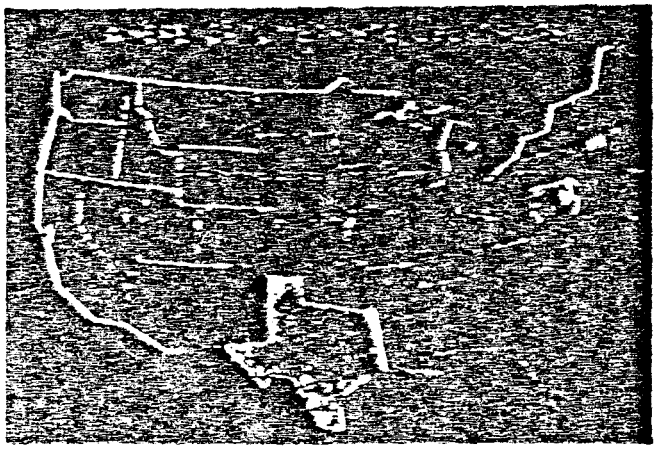
DRUG UPDATE

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.

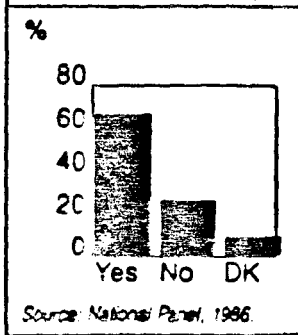
Another problem is the cost of doing surgery. O.D.'s would have to undergo training, and buy equipment such as reclining exam chairs, foreign body spuds, and rust ring drills. O.D.'s also would probably have to pay higher malpractice premiums. "On the one hand, surgery would increase our patient pool," 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." ■

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



Source: National Panel, 1986

SENATE HEALTH & WELFARE
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DATE 1-26-87
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GEORGE DeBELLY, M.D.
BOZEMAN MEDICAL ARTS CENTER
300 NORTH WILLSON AVENUE
BOZEMAN, MONTANA 59715

Telephone 587-4245

January 29, 1987

The Honorable Dorothy Eck
Montana State Senate
Capitol Station
Helena, MT 59620

Dear Senator Eck:

Recently Dr. Rasmussen introduced Senate Bill No. 170 which would allow optometrists to become medical practitioners while using drugs for therapy of the eye.

I am very much opposed to this bill and I would urge you to vote against it. The best summary of the basis for this opposition is outlined in the summation sent to you by the Montana Academy of Ophthalmology entitled "Therapeutic eye care of Montana". I would like to urge you to review this letter and especially note the difference in training between an optometrist and an ophthalmologist. The other point I would like to stress is that during the four years spent in medical school, a great deal of time was spent in the physiology and pharmacology lab studying the effects of drugs on the whole system not just one isolated area such as the eye.

Again, I would like to emphasize that the eye cannot be separated from the rest of the body when therapeutic drugs are used. I wish to urge you to vote against this bill.

If I can be of any further assistance, or you have any questions, please feel free to call me.

Sincerely yours,

George DeBelly, M.D.

George DeBelly, M.D.

GD:cw

Shelby Clinic
Box 519 — 925 Oilfield Avenue
Shelby, Montana 59474
434-5595

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 1-26-87
BILL NO. SB170

January 21, 1987

Senator Dorothy Eck
Chairman of Senate
Public Health Commission
Capital Station
Helena, MT 59602

Dear Senator Eck:

It has been brought to my attention that there is legislation pending which would allow optomitrists to perform medical treatment of anterior segment eye diseases. It is my understanding that this would include such things as conjunctivitis, mild iritis and possible foreign body removal from the cornea.

Optomitrists are by training and experience capable of performing these services. They have the necessary equipment in their office to make accurate diagnosis. Optometry students are given extensive courses in occular pharmacology. In addition to that they have continuing medical education opportunities to maintain and improve their knowledge in this field.

It is obvious that patients would benefit directly because they would not have to have additional trips to physicians for simple anterior segment disease. This would same time, money and discomfort associated with referrals.

I feel that optomitrists should be permitted ~~for~~ to practice at the level commensurate with their education and training. They should have to meet standrads in occular pharmacology and demonstrate necessary skills of diagnosis and treatment in the same way that other health care professionals are required to do. I am not in favor of grandfathering in optomitrists, but I feel that they should have to meet specific standards.

I personally refer patients quite frequently to one of the local optomitrists for assistance in differentiating between iritis and other forms of the red eye syndrome. As such they have been very helpful. Our closest opthomologist is 85 miles away and being able to use a local optomitrist saves my patients considerable amount of time, money and discomfort.

I therefore favor legislation which would allow optomitrists to treat anterior segment eye disease. I find no reason why our lawmakers would not act favorably on this pending legislation.

Sincerely yours,

Robert F. Stanchfield, M. D., P.C.
RFS/cp

cc: President of MOA

SENATE HEALTH & WELFARE
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MONTANA OPTOMETRIC ASSOCIATION

P. O. BOX 908 HELENA, MONTANA 59624
PHONE (406) 442-1432

January 29, 1987

Senate Public Health Committee
Capitol Station
Helena, MT 59602

RE: Senate Bill 170

Dear Committee Members:

I was carboned on several letters from physicians that were sent to Chairman Eck.

I wish to call your attention to these letters of support for our association's position.

Thank you.

Sincerely,

Larry Bonderud O.D.

Larry J. Bonderud, O.D.
President, Montana Optometric Association

LJB/rmj

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Box 519 — 925 Oilfield Avenue
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RFS/cp

cc: President of MOA

SENATE HEALTH & WELFARE
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COMMUNITY HEALTH CARE CLINIC

January 21, 1987

Senator Dorothy Eck
Chairman, Senate Public Health Committee
Capital Station
Helena, Montana 59602

Dear Senator Eck:

I have become aware of Senate Bill 170, which, if passed, will allow optometrists to treat anterior segment eye diseases. I wish to express my support in favor of this legislation for the following reasons:

1. Optometrists are highly trained primary care practitioners who have the knowledge and equipment to make the correct diagnosis and treatment for patients with eye diseases. They are professionals and also know when to refer to other health care practitioners when the condition falls out of the scope of their expertise.

2. Patients would benefit directly because they would not have to make unnecessary trips to additional health care practitioners, thus saving, money, time and the prolonged discomfort associated with referrals,

3. Optometrists should be permitted to practice at a level commensurated with their education. Restricting optometrists from treating anterior segment eye diseases is unnecessary, unfair and only serves to keep the costs of health care unnecessarily high.

I therefore wish to express that I find no justifiable reason to opposed this legislation as it is for the positive benefit of the public. I sincerely hope our lawmakers have the wisdom to recognize the merits of this pending legislation and will enact it in to law.

Yours truly,

Lawrence A. Hemmer, Jr., M.D.

LAH/ag

Copy: President MOA

226 9TH AVENUE S.E., CUT BANK, MONTANA 59427 (406) 873-5507

JOSEPH C. TOLAND, M.D.
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MEADOWBROOK, PA. 19046

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 1-26-87
BILL NO. SB 170

January 19, 1987

Senator Dorothy Eck
Capital Station
Helena, Montana 59620

Dear Senator Eck:

I understand that you are considering a bill which would allow Montana optometrists to use therapeutic pharmaceutical agents in their practices. I have been asked to contact you regarding my support of such a bill based on my direct clinical teaching experiences in both optometric and ophthalmological training programs.

I am a board certified ophthalmologist who has taught in both ophthalmologic and optometric educational institutions. In such a dual capacity, I am best able to compare the clinical exposure in ophthalmologic and optometric teaching clinics.

My sixteen years of joint clinical teaching experiences confirms the fact that ophthalmological training programs concentrate more on advanced medical and surgical cases, while clinical optometric programs provide equal teaching experience in eye disorders and diseases at the primary care level.

Sincerely,

Joseph C. Toland, O.D., M.D.

JCT:eh

Enclosure

bc: L. Bonderud, O.D.

Poe & Associates, Inc.
P.O. Box 1348/Tampa, Florida 33601-1348
(813) 222-4100
Telex 52-629

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 1-26-87
BILL NO. SB170

October 28, 1986

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

RE: Therapeutic Drug Usage

Dear Mr. Lex:

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

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

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

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

Sincerely,

Stanley R. Kloszewski
Senior Vice President

SRK/sy

cc: Bill Reinertson, American Optometric Assoc.

SEN[illegible] & [illegible]RE
E[illegible] 9
DATE 1-26-87
BILL NO. S.B.170

GALLATIN INTERNAL MEDICINE CLINIC

300 NORTH WILLSON, SUITE 2002
BOZEMAN, MONTANA 59715
TELEPHONE 406/586-0211

DOUGLAS W. ALVORD, M.D.
DIPLOMATE OF THE AMERICAN
BOARD OF INTERNAL MEDICINE

STEVEN L. SHANEYFELT, M.D.
DIPLOMATE OF THE AMERICAN
BOARDS OF INTERNAL MEDICINE
AND GASTROENTEROLOGY

WILLIAM E. NEWSOME, M.D.
DIPLOMATE OF THE AMERICAN
BOARD OF INTERNAL MEDICINE

January 27, 1987

Senator Dorothy Eck
Montana State Senate Capitol Station
Helena, Montana 59620

Dear Senator Eck,

It has come to my attention that there is a bill presently before the State Senate, bill #170, which would allow Optometrists to use drugs for therapy of teh eye. As an internal medicine specialist, I think this would be a serious mistake. It is my experience that various eye diseases are commonly a manifestation of internal illnesses, including such fairly common illnesses as rheumatoid arthritis, cerebral vascular disease and diabetes. I don't believe that Optometrists have the experience and training to regonize and treat these potentially serious disorders.

I appreciate your attention to this issue and thank you for consideration.

Sincerely,

William Newsome, M.D.

WEN/ph

...TH & WELFARE
EXHIBIT NO. 9
DATE 1-26-87
BILL NO. SB 170

JOHN R. TKACH, M.S., M.D.
300 North Willson
Bozeman, Montana 59715
Phone (406) 587-5442

January 28, 1987

Senator Dorothy Eck
Montana State Senate
Capitol Station
Helena, Montana 59620

Dear Senator Eck,

I am writing to you to urge you to vote against Bill #170 to allow optometrists to use drugs for therapy of the eye. While ophthalmologists may be contacting you to express their concerns, my orientation is a little different. I am a dermatologist.

Daily, I see and treat tumors and infections around the eyes and on the eye lids. This is very tricky stuff. There are about 5,000 dermatolgic conditions that occur in these areas. Even with my boards in dermatology, dermatopathology, with biopsies, and a master's degree in microbiology, it is often difficult for me to diagnose these conditions.

A major factor in treating conditions on the eyelids and around the eyes is making the correct diagnosis early. Failure to do so can lead to destruction of the eye. Optometrists simply do not have the training to do this. It takes years, and they are not qualified to do it. It is as simple as that.

A second major consideration is early recognition of bacterial infections of the eye. This is a very serious condition. Unless the diagnosis is made early and I.V. antibiotics are started, the patient is likely to lose the eye. Optometrists do not have the training to do this. On several occasions, I have seen optometrists misdiagnose and mistreat simple conjunctivitis.

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
1-26-87
BILL NO. SB170

For these reasons, I urge you not to let Bill #170 pass. Looking at it another way, would you want someone who doesn't know what he's doing mucking around with your eyes?

With warmest greetings and thanks for your consideration,

Yours truly,

John R. Tkach

John R. Tkach, M.S., M.D.