STATE OF NEBRASKA

DEPARTMENT OF HEALTH

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M E M O R A N D U M

TO: Senator Don Wesely, Chairman
Health and Human Services Committee

FROM: Gregg F. Wright, M.D., M.Ed.
Director of Health

DATE: February 9, 1990

SUBJECT: Recommendations Regarding the Optometric Proposal for a Change in Scope of Practice

Recommendations

In their original proposal, the Nebraska Optometric Association requested a change in scope of practice that would allow optometrists to use oral medications to treat eye diseases in general, and to use both oral and topical medications to treat glaucoma. During the review, the proposal was amended to require that an optometrist "communicate and collaborate with an ophthalmologist" before prescribing or administering oral or topical agents in the treatment of glaucoma.

The technical committee recommended approval of the proposal as amended. The Board of Health concurred with this recommendation.

The Department recommends against approval of the proposal for the reasons discussed below.

Criteria

Nebraska law provides that the scope of practice of a regulated health profession shall be changed only when:

a. The present scope of practice or limitations on the scope of practice create a situation of harm or danger to the health, safety, or welfare of the public, and the potential for harm is easily recognizable and not remote or dependent on tenuous argument;

b. The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public;

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c. The enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public, and;

d. The public cannot be effectively protected by other means in a more cost effective manner. (Neb.Rev.Stat. 77-6221)

After a thorough review of the application, the entire public record created by the technical committee, the technical committee report, the Board of Health report and the discussion of the Board of Health, it is the firm opinion of the Director of Health that this application does not demonstrate a current potential for harm, and the proposed change does demonstrate a significant new danger to the health, safety, or welfare of the public and would provide minimal benefits.

Discussion:

The circumstances of this application warrant dealing separately with the removal of restrictions for the treatment of glaucoma, and the other oral medications.

Glaucoma Treatment

The technical committee, the Board of Health, and the department are all in agreement that the unrestricted treatment of glaucoma by optometrists is not warranted. A large amount of testimony at the public hearing and of discussion by the committee was devoted to this question. The evidence was overwhelming that optometrists do not have appropriate training or expertise to manage this complex disease alone. Because of this discussion the applicant group modified the proposal to require that before treating glaucoma, with either oral or topical medication, the optometrist must "communicate and collaborate with an ophthalmologist." With this amendment, but with little discussion of how it might be carried out, the technical committee voted to approve the application.

When the Board of Health discussed the application, the major discussion centered on whether such a last minute amendment is in keeping with the letter or the spirit of the credentialing review process. This appeared to distract attention away from the question of how such an amendment would work, and from the other issues raised by the proposal.

The requirement for "communication and collaboration" is an unworkable provision that does not provide protection. The important term in the amendment is "collaboration." Simply to require "communication" between an optometrist and ophthalmologist before instituting treatment for glaucoma would provide no protection. Collaboration implies a "working together" for a common goal. This implies that both optometrist and ophthalmologist would be working together in the treatment of the patient, and that therefore both would share responsibility for the treatment. This would only be workable if both optometrist and ophthalmologist were to examine the patient, or if there were some defined delegation arrangement

between them in the same manner as a physician-physician assistant relationship. Obviously both would have to be licensed in Nebraska. Neither of these mechanisms would provide a viable method of insuring the protection that would be needed.

Oral Treatment other than Glaucoma

The remainder of this report will deal with the question of whether the scope of practice of optometrists should be changed to allow them to treat with oral medications.

There has not been a demonstration that the current limitations on the scope of practice of optometry create a situation of harm or danger to the health, safety, or welfare of the public which is easily recognizable and not remote or dependent on tenuous argument.

The application argues that there are three "weaknesses" in the current situation: standard care from many ocular conditions requires treatment with oral medications; additional costs are incurred if patients must go to a second practitioner; and patients should be free to choose their care giver.

On the first point, there is no question that oral medications are required for the care of some conditions affecting the eye. However, intravenous medications are required for some conditions affecting the eye, and surgery for others. The question must be where to draw the line between optometrists, who specialize in diseases of the eye, and physicians, including ophthalmologists, who specialize in the treatment of the human body including the eye. Currently the law draws the line by allowing optometrists to treat those conditions which can be treated by topical medication and involving a physician when systemic treatment is needed. There was no evidence presented that drawing the line in this way causes unnecessary risks to health, safety, or welfare. Usually, when oral (systemic) treatment is required, it is an indication that other systems of the body are also affected and the treating practitioner must be familiar with the treatment of the entire human body.

Beginning on page 18 of the application, several infectious conditions are mentioned which demonstrate the weakness of not allowing optometrists to treat with oral medications, including chlamydial conjunctivitis, internal hordeolums and chalazions, and herpes zoster. Dr. Phil Smith, a specialist in infectious disease at Clarkson Hospital responded at the public hearing to each of these. He pointed out that chlamydial conjunctivitis is extremely rare except in the newborn period when it is also associated with pneumonia, a condition clearly requiring the care of an experienced physician. Dr. Smith testified that internal hordeolums and chalazions do not generally require oral antibiotics unless there is a degree of facial cellulitis or periorbital infection both of which are serious medical conditions, and that oral antiviral medications are only indicated in severe or generalized herpes zoster, both of which require medical expertise.

The application also indicates that harm is done by not allowing optometrists to treat with oral pain medication, for example Tylenol with Codeine. A consultation with ophthalmologists in two different states indicates it is rare that medication stronger than plain Tylenol, which can be obtained over the counter, is needed to treat patients after removal of a foreign body. It does not make sense to add another class of practitioners who are authorized to use controlled substances, all of which have a potential for addiction. It is entirely possible for optometrists and primary care physicians to cooperate in the treatment of the unusual patient who needs additional pain medication after removal of a foreign body.

The strongest argument that the current situation creates harm is the harm to the welfare of the patients caused by unnecessarily requiring them to see a second practitioner for complete care. There was no demonstration that this is a serious financial problem with our current system, especially if it is realized that when systemic disease, or systemic complications of eye disease are present, the second visit should not be characterized as unnecessary. Primary care physicians are available in most communities in which optometrists are practicing. Ophthalmologists demonstrate a good coverage of the state for specialized eye care requiring a physician.

<u>The proposed change in scope of practice does create a significant new danger to the health, safety, or welfare of the public.</u>

There is a great deal of evidence in the record generated by this review that the current training of optometrists is not sufficient to allow the safe assumption of oral pharmaceutical therapy with only 44 hours of additional training.

The training given by the 16 schools of optometry across the country varies greatly in the amount and quality of the training related to treatment with systemic medication. The Pennsylvania College of Optometry in Philadelphia has probably gone the furthest to address this as a component of optometry practice, and ironically, the State of Pennsylvania does not authorize optometrists to treat with oral medication. Dr. Lewis, the current president of this college, acknowledged the variability in the training at the sixteen sites, but pointed to the system of state and national board exams as the "safety factor" that is built into the system. Tests, however, cannot be the first line assurance of quality. Unless there is a standardization of the curriculum given, no test alone can assure minimum competence.

Dr. Robert Waldman, Dean of the Medical School, testified to his concern about the adequacy of the education of optometrists. He stated that, "Physicians are allowed to prescribe these types of medications only after having had two years of basic medical sciences including biochemistry (over 200 hours), physiology (about 250 hours), microbiology (about 200 hours) and pharmacology (about 250 hours), two years of clinical training in medical school, during which most of the emphasis

is on the indications, uses, and particularly the contraindications, side effects, drug interactions, and toxicities of medications, and finally three to seven years of residency training." He goes on to say that "Systemic antibiotics must be used with care, and only after careful analysis of the clinical situation, because of drug interactions, antibiotic side effects, and the development of resistant organisms. I believe that the prescription of these medications by inadequately trained providers could lead to adverse health effects."

Perhaps the most convincing testimony was by Dr. Craig Lannin, who was first trained as an optometrist, and in fact was a faculty member in a college of optometry, and then went back to osteopathic school (which is essentially equivalent to medical school) and became an ophthalmologist. After first hand experience with the training of both optometrists and ophthalmologists, he testified that optometric training did not provide an adequate basis for using systemic medications. Dr. Lannin testified that "The keystone of training and acquiring clinical expertise lies in direct patient encounters. Because of the large number of optometric students when compared to the number of ophthalmology residents, the distribution of available patients leads to ophthalmologists seeing very many more patients during their training than optometrists do during theirs. In my personal experience, the number of patients that I saw during my optometric training was equaled or exceeded by the number of patients which I performed surgery on alone, during ophthalmologic residency, to say nothing of the thousands of patient encounters in clinic and in hospital consultations, and in emergency room evaluations. In addition, the vast majority of patients I saw during optometric training did not have any significant ocular disease."

The system set up by this proposal exposes the weakness of the assumptions used. An optometrist who is currently licensed for standard optometry with no additional certifications, would have to take a 100 hour training course to become certified to use diagnostic topical medications, an additional 100 hours to become certified to use topical therapeutic medications, and then only 44 hours to become certified to use oral therapeutics including oral antibiotics, oral steroids, and oral narcotic analgesics. Clearly the expertise and training, and the understanding of human physiology, pharmacology, and microbiology are much greater in making the last transition to oral therapeutic agents.

Summary:

This review differs from the conclusions arrived at by the technical committee and the Board of Health. The glaucoma issue and the revision of the application did appear to influence the first two reviews.

All three reports agree that the optometrist should not treat glaucoma, with either topical or systemic medications, on their own. The method suggested by the applicant group, to require "communication and collaboration" does not provide a sufficiently defined, workable mechanism for providing the needed protection and assurance.

There was no demonstration that the current restrictions on the scope of practice of optometry - restriction to the treatment of eye disease with topical medication only - causes any harm or danger to the health, safety or welfare of the public.

On the other hand, the review of the record indicates that the proposed change would create a significant new danger to the health, safety, or welfare of the public.