STATE OF NEBRASKA

ROBERT KERREY • GOVERNOR • GREGG F. WRIGHT, M.D., M.Ed. • DIRECTOR

MEMORANDUM

TO: Senator Donald Wesely

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

SUBJECT: Recommendations Regarding a Change in Scope of Practice of Optometrists

DATE: January 3, 1986

Introduction

In preparing my recommendations on the optometrists proposal, I have attempted to conform to both the letter and the spirit of LB 407. My principal concern has been to try to assure that there has been a reasonably uniform interpretation and application of the philosophy, criteria, and procedures required by the act.

The language of LB 407 is quite specific in identifying the three criteria that must be satisfied by any group seeking professional credentialing. Briefly stated, these are that there must be clear evidence of harm to the public resulting from the lack of regulation; that the public must need and benefit from an assurance of minimum standards of competence; and that no method other than regulation by the state provides for cost-effective protection of the public.

However, the statute gives little guidance as to what criteria should apply to a proposal for a change in the scope of practice of a profession or occupation currently regulated by the state. Each technical committee has had to determine an appropriate way to apply the intent of LB 407 in these circumstances. In general, the committee attempted to focus its attention on the question of harm to the public resulting from the current situation (i.e., the perceived problems that gave rise to the proposal for a change in the scope of practice) and of the potential harm or benefit to the public resulting from enactment of the change. The committee was, in effect, comparing a real and a hypothesized environment and endeavoring to determine which of those provided the best balance of public protection and cost-effective regulation.

I have attempted to identify each of these elements in the committee report, and I have scrutinized the application, and the evidence and

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testimony submitted by all parties. In making my recommendations, therefore, I have reviewed the same material that was used by the technical committee. But I have also been guided by the intent of LB 407 to provide a uniform application of a broad philosophy of regulation to all applications. I take this philosophy as one that views state regulation as a means of last resort. This philosophy finds the necessity for regulation to rest almost exclusively in the need to protect the health, safety, and welfare of the public from the prospect of widespread and significant harm. It seeks to balance this necessity against the very real economic and social costs of regulation, such as restriction of competition, potential increases in the cost of health care, limitation of the availability and accessibility of services, and increases in the size and cost of state government.

The application of this broad philosophy may at times lead to a somewhat different interpretation of the evidence submitted from that arrived at by the technical committee. I hope that any such different interpretations will be viewed, not as sharp differences of opinion between the Director of Health and the technical committee, but rather as the natural shift of emphasis and priority that occurs when one moves toward a more global perspective.

In this light, I submit the following comments and recommendations regarding the proposal for credentialing of the optometrists.

Recommendations

The Nebraska Optometric Association sought in its proposal to expand the scope of practice of optometry to allow the use of pharmaceutical agents by properly trained optometrists to treat the human eye, adnexa, and vision systems. The therapeutic agents used would include topical and oral antimicrobal agents, topical and oral antihistamines, topical and oral antiglaucoma agents, topical anti-inflammatory agents, and oral analgesic agents. The proposal also sought to allow qualified optometrists to remove superficial foreign bodies from the eye and adnexa.

The technical review committee rejected this proposal. Instead the committee recommended that properly trained optometrists be permitted to use topical ocular pharmaceutical agents to treat eye infections, inflammation, and superficial abrasions, but that no oral agents or antiglaucoma agents of any kind be used by optometrists.

After a consideration of this application, the transcript of the public hearing, and the committee report, I recommend that no changes be made in the optometric practice act.

Discussion

In reviewing the record compiled during the course of this review, I was struck by how quickly and firmly the technical committee's focus seemed to settle on the issue of the nature and extent of the clinical training provided to optometrists. It appears clear that the committee's deliberations and ultimate decision were deeply influenced by their perception of what did or did not constitute adequate training to use pharmaceutical agents. This perspective seems to have been encouraged by the frequent comparisons, made by both principal parties in the debate, between the training and skills of an optometrist as opposed to those of an ophthalmologist.

As this course of consideration developed, a crucial point seems to have been given only peremptory consideration: are the practices of an optometrist more appropriately compared to those of an ophthalmologist or to those of a primary care physician? Frankly, it was more expedient for each party to choose to compare optometrists to ophthalmologists. Optometry could then argue that availability and cost of services were crucial issues that could be redressed by expanding the scope of practice of the profession. Medicine, on the other hand, could point to the discrepancy in the levels of clinical training in the management and treatment of eye disease achieved by the two groups as evidence that such a move would expose the public to potential danger.

In my view, however, the appropriate comparison is between optometrists and primary care physicians. Each of these groups of practitioners is qualified and licensed to engage in some aspects of eye care. Each refers more complex cases to ophthalmologists. Each deals in a practice where eye disease is only infrequently encountered, and where clinical training in the management and treatment of eye diseases does not constitute the major aspect of their training. The optometrist generally has greater knowledge of the mechanics of the eye and the physics of vision, while the physician generally has greater knowledge of the relationship of the eye to other body systems and of the overall systemic effects of therapeutic pharmaceutical agents.

The committee appeared to give great weight to harm the public may be currently suffering because ophthalmologists are so much less accessible, both in distance and in cost, than optometrists in Nebraska. However, if the appropriate comparison is not with ophthalmologists but with primary care physicians, the arguments for changing the scope of practice become much less compelling. The number of primary care physicians in Nebraska is greater than the number of optometrists, and their distribution is such that there do not appear to be any areas of the state where an optometrist is easily available and a

primary care physician is not. Thus the availability of services argument is moot. The relative cost of services between optometrists and primary care physicians has not been presented. It is likely that optometry services are somewhat lower in cost, but it is almost certain that the discrepancy in service costs is much less than that between optometry and ophthalmology services. The argument that optometrists' offices are generally better equipped for eye examinations may be well-founded, primarily as it involves the availability of a slit lamp for examination. However, many hospitals would have this equipment available to the physician. This consideration underscores the importance of a single, cooperative system of care rather than the development of parallel and unrelated systems.

Shifting the comparison to one between optometrists and primary care physicians changes the concerns over the level of training of optometrists. What emerges is a clear picture of two independent health care professions whose areas of practice overlap with respect to eye care. The question then becomes, "Where is the appropriate place for a person to go if they are concerned about red, sore, or itchy eyes; to the local optometrist, or the local primary care physician?" I believe at this time the correct answer is clear and that the physician should be consulted. As far as the use of therapeutic agents is concerned, physicians already have this activity as part of their practice act. There is no evidence that there is any shortage of physicians or other cause that would render the service unavailable to most Nebraskans. Therefore, there seems to be no compelling reason to expand the scope of practice of optometry to include this area. This is reinforced by the clear evidence that although topical medications are applied to the eye, they are rapidly absorbed and become systemic. This proposal does not contain justification enough to carve off this part of the practice of medicine and assign it to another practitioner.

The training argument deserves one additional comment. According to the above considerations, the appropriate training comparison should be between optometrists and primary care physicians. Assertions were made that the training of physicians in the care of the eye has diminished in recent years, and this was countered by assertions that their training is adequate. No evidence was presented that would show that primary care physicians are not adequately treating eye disease as they are currently trained, and this proposal is not presented as a solution to a problem in the training of primary care physicians. If this were the assertion, however, the appropriate remedy would involve education and enforcement of the profession of medicine, and not necessarily a reassignment of a part of the practice of medicine to another professional group.

An argument could be made that the care of the eye has become so specialized that this practice should be removed from the practice

of medicine and assigned to an eye specialist only. This has happened with the care of the teeth and has resulted in the profession of Dentistry. Although a physician can, within his or her scope of practice, treat dental caries by filling teeth, few physicians would consider this and those that do accept the necessity of additional dental training and dual licensure. If this logic were applied to the eye, optometrists could conceivably assume the primary care of the eye with referral to subspecialist ophthalmologists as necessary, in the same way that dentists refer more complicated problems to oral surgeons. However, this is not at all what is argued by the applicants. In fact, they stress the routine nature of such treatment as an argument that such care could be safely assumed by optometrists. I do not believe that a case has been made at this time to consider the treatment of eye disease as a special function that should be dealt with only by eye specialists.

LB407 carries with it the clear message that a practice should not be regulated if it is not necessary for the health and safety of the public. This raises the question whether this application should be accepted even if the positive need for it is not compelling. I would argue that it should not, primarily because this is not, in fact, a proposal to deregulate a practice as much as it is one that shifts the regulation to another place. The practice of treating eye diseases would still be regulated, but under the proposal would be regulated by both the Board of Medicine and Surgery and the Board of Optometry.

In making this determination, I have also given consideration to the importance of maintaining a coherent health care system rather than a fragmented system. It is important that to the degree possible the separate components relate to each other in a rational and understandable way. The training an individual health care profession provides to its members should not give cause to fragment the system without good justification. As an example, it is conceivable that audiologists could add to their training the knowledge and skills necessary to treat infections of the middle and outer ear; physical therapists could add the knowledge and skills pertaining to treating common muscle and joint diseases and even simple fractures; and perhaps cosmetologists could add training pertaining to the treatment of scalp diseases and ringworm. In each case, a division would have to be made between those diseases which could be treated locally, and those that would have systemic effects, and as with diseases of the eye, I believe this line would be artificial and tenuous. Even if it could be drawn, I am certain that the health care of patients in general would not be served by such fragmentation.

Finally, if the Legislature does determine that a need exists to expand the scope of practice of optometry in this fashion, then I would urge the Legislature to consider an alternative which would reduce the chance of fragmentation of care. This would be to permit the application of topical therapeutic agents to be performed by optometrists only under the general supervision of a licensed physician. General supervision is used here to imply an ongoing relationship between the two professionals with periodic and regular personal contact and a review of charts by the supervising physician. This would acknowledge the capability of the optometrist to function with minimal supervision, but would acknowledge the ultimate responsibility of the physician for the medical care rendered. By doing this the Legislature would recognize that there may be instances where the application of therapeutic agents by an optometrist can be the most efficient and cost-effective means of providing this service to the public, and at the same time state clearly that the the protection of public health requires that all medical procedures be performed under the ultimate responsibility and authority of a physician. I recognize that the history of dispute between the two professions may make such a suggestion difficult to swallow for either side. It would, however, have the effect of maximizing flexibility within a unified system of care that clearly avoids the danger of fragmentation of care. It might be that such a system could be instituted for a five-year period on a trial basis, and that an examination of the record at the end of that period would provide more information to direct future policy.

GFW/blw

cc: Senator Harry B. Chronister
Senator Timothy J. Hall
Senator Dan Lynch
Senator Richard Peterson
Senator Jacklyn J. Smith
Senator Ron Withem