The meeting was called to order at 12:45 p.m. in Room 213 of the Legislative Building.

Senator Wilson in the Chair.

PRESENT: Senator Thomas R.C. Wilson, Chairman
Senator Richard Blakemore, Vice-Chairman
Senator Don Ashworth
Senator Melvin Close
Senator William Hernstadt
Senator Clifford McCorkle
Senator Cliff Young

ABSENT: None

OTHERS PRESENT: Guest List attached as Page 1A

AB 580 Authorizes certification of optometrists to use in their practice certain drugs without prescription.

Don Hill, Attorney at Law, said he was in opposition to dividing the bill up into topics for testimony. It was decided that the bill would be heard on a proponent/opponent basis with time for rebuttal.

William Van Patten, O.D., President of the Nevada State Optometric Association and a practicing optometrist, spoke in support of AB 580. He said everything that they would present that day would be a positive approach. (Exhibit A in the Legislative Research Library.)

Dr. Van Patten said there were three points he wanted to make. First, the optometrists were not asking for anything new. These few drugs have been used for nearly a quarter of a century since the present law was rewritten in 1955. Secondly, he wanted to show evidence that optometrists are qualified to diagnose ocular disease as well as ocular manifestations of systemic disease. The third point was that when these diagnostic pharmaceutical agents are used appropriately under professional supervision, they are not dangerous and are safe.

Dr. Van Patten referred to a Department of Health and Welfare Study, (Exhibit B which can be referred to in the Legislative Research Library). He closed his testimony by saying that the recommendation from this study, mandated by Congress, was that the state licensure laws be revised to include the diagnostic drugs throughout the United States. If these drugs were dangerous, it seemed inconceivable to him that such a prestigious group as made up the HEW study would recommend the state licensure laws be revised. Dr. Van Patten also included in his testimony a copy of a letter from the Department of the Army (Exhibit C) and information from Albert N. Lemoine, M.D., of the university of Kansas Medical Center, College of Health Sciences and Hospital (Exhibit D).

Senator Hernstadt said he thought the biggest concerns that the ophthalmologists have are unexpected and surprise side effects from some of these topical agents and an optometrist not knowing how to

deal with it.

Dr. Van Patten said that they had learned in a pharmacology course as well as in other courses the C.P.R. method in giving first aid to someone who had side effects.

Kenneth Polse, O.D., a member of the faculty of the University of California in the Department of Optometry, spoke as an individual and an optometrist. He cited some instances in his experience as an optometrist with the use of these drugs, both since this law was passed in California, and in his two years experience in the Department of Optometry. He said he is presently the Director of Clinics at the University of California School of Optometry and he spoke of what optometrists use these drugs for and what the issue bears down to from the standpoint of optometrists. The issue really boils down to the prevention of blindness, the early detection of ocular disease that may either have systemic effects or ocular effects, but it is mainly for early recognition so that the optometrist can refer these people to appropriate medical diagnosis and therapy. This is the sole reason for the use of these drugs which will allow earlier recognition.

Dr. Polse handed out a table that points out the four principal classifications of drugs and the purposes for which they are used (see Exhibit E). He said the use of these drugs allows the optometrists to use certain types of optical instrumentation for a more thorough examination of the eye than they presently have.

Dr. Polse said the clinic at the University of California has had 60,000 approximate patient visits and about 1/3 of the patients have received these drugs as part of the normal course of examination and within this group they detected some of the following conditions: early retinal detachment, glaucoma, assorted diseases of the back of the eye, brain tumors, increased hypertension and miscellaneous diseases. He guessed that 3% or 4% of the 600 or 700 patients would not have had their eye problems detected if they had not had the use of these diagnostic agents.

Senator Hernstadt asked of the 25,000 that had topical drugs applied, how many experienced allergic reactions. Dr. Polse said there were none. He said the only types of reactions that they saw and those very rarely, were mildly red eyes, 3 or 4 patients fainted and they had one case of topical dermatitis, which was referred to an ophthalmologist, which was probably an allergic reaction to one of the preservatives in the drug. There was never any permanent damage suffered.

Senator Hernstadt asked if this issue were an economic one. Dr. Polse said he thought the issue was very complex, partly economics and it is also partly a psychological and emotional issue. Dr. Polse read a letter to Marvin Sedway, O.D. from Harrie Hess, Ph.D. (see Exhibit F).

Richard Hopping, O.D., optometrist, spoke in behalf of AB 580 as a representative of optometric education and as president of the third

oldest optometric education institution in the nation. His entire testimony is contained in Exhibit G. He also submitted a manual for the use of topical pharmaceutical agents (Exhibit H).

Keith McDonald, pharmacist, addressed the question of relative safety or danger of diagnostic pharmaceutical agents. He said there are many pharmacological products that are available on the shelves in the local pharmacy that are absolutely dangerous if misused. He said twelve dramamine tablets causes hallucinations and an overdose of aspirin can cause death; there are many allergic reactions and fatal reactions to pharmaceutical products or drugs. He thought it was important that the strength of medication that is being mentioned here is relatively safe topically. He said the question revolves itself around administration of medication. He said the final analysis is that in the use of any diagnostic pharmaceutical agent, it should be made on the potential risk and the potential benefit, and in this case he thought it was a relatively minor risk compared to what can be bought in any drug store compared to the benefit that would be greatly outweighed by having these proper diagnostic agents.

Seret Gaanus, pharmacologist, spoke in support of AB 580. She said she had been invited to testify by the Optometric Association because she had been involved intimately with optometric legislation in California.

Arrah C. Curry, M.D., spoke in opposition to AB 580. He said his practice is limited to general ophthalmology. He submitted an outline of his testimony in booklet form (Exhibit I, which can be obtained in the Legislative Research Library). He also submitted letters of support (Exhibit J) and a statement by Albert N. Lemoine, M.D., F.A.C.S. (Exhibit K). Dr. ACurry spoke of the advertising the Optometric Association had done to get this legislation in front of the public eye in the Reader's Digest, Ladies' Home Journal, Newsweek and television prime time (Exhibit L).

Senator Wilson said the bottom line issue was whether or not, by the processing of this bill, they should authorize the utilization of diagnostic drugs or expand the definition of the practice of optometry. He said the central issues are the use of the diagnostic drugs today and whether it poses a legitimate hazard to the public and whether or not the optometrist is qualified to administer drugs and qualified to recognise the diseases or problems for which the drug is used to diagnose in the first place.

Neil Swissman, Nevada State Medical Association, spoke in opposition to AB 580. He read prepared testimony (Exhibit M).

Dr. M. Pearlman, Ophthalmologist in Las Vegas, spoke in opposition to AB 580. He said that ophthalmology is unique in that it covers all ages and both sexes and many diseases are sensed in the eyes.

Dr. Pearlman said that the key arguments that had been heard were

that optometrists need these drugs; they're knowledgable on how to handle these drugs; they are safe drugs and he said these statements are only half true. They are safe and they are needed, but the point he was making was that this should be permitted so that the ophthalmologists can diagnose and therefore make the proper disposition. The whole point is missed. He said to stick to the guy who's been trained to do the job and do it right. He said that it couldn't be denied that by using these drugs more can be seen. But the fundamental question is not just regarding safety but is it the business of the optometrist to diagnose disease.

Dr. Pearlman mentioned a mailogram that he had received from Dr. Lemoine in which he stated that in his opinion, topical miotic drugs were not for diagnostic purposes; topical mydriatics and cycloplegics can be used for diagnostic purposes.

Dr. Pearlman told of some case histories which were rather drastic in which there were incorrect diagnoses made by optometrists. He said that he used these examples to make the point that he would like to see optometrists recognize and understand when to refer a patient to an ophthalmologist. He gave four reasons for a patient to be referred to an ophthalmologist: 1) if his vision is uncorrectable; 2) if he has a discolored eye; 3) if there is a disfigurement of any part of the eye; and, 4) if there is pain.

Senator Wilson asked if it was necessary to the process of recognizing that something is wrong that a diagnostic agent be used. He said if the answer is yes, then they would have to talk about under what kind of conditions and with what qualifications.

Dr. Pearlman said he thought the alternatives for the legislature would be to ask the medical profession and the optometric profession to get together and find an answer to this problem by putting this bill into study and finding out how to reach a common ground. He referred to a list of ailments that should be considered when using topical drugs (Exhibit N). He said this bill would create a pseudo-M.D.

John Tate, manager of Southern Nevada Sightless, and who worked in the field for the blind for 30 years, spoke on AB 580. He felt that giving a patient a sound diagnosis and appropriate treatment was vital. He said that Nevada law and federal law both stipulate that, before any money can be spent by a state agency for an eye treatment, the patient must be examined by an ophthalmologist and not an optometrist.

Geoffrey Cecchi, M.D., ophthalmologist and optometrist, spoke on AB 580. He gave an essay on the differences between the two professions and felt he had a unique view of the subject. He felt the study of pharmacology was not sufficient to dispense topical drugs but that physiology and all the other disciplines involved in the practice of medicine were needed as well.

Dr. Cecchi said the risk is not just in the reaction of a drug, the risk encompasses all the aspects of an optometrist using these drugs. The risk in an optometrist using the drugs is in the possibility of a reaction, the identity problem in the public distinguishing between an M.D. and an optometrist and the delay in referral because of unwarranted false sense of security by the optometrist. He said for the record that there would be some potential benefit in optometrists using these topical agents. He said the potential benefit would be that there are a certain amount of people that would come in the office that would not have symptoms and that would have pathology hidden behind the small pupil that would go unrecognized if the pupil were not dilated. He said his point was that the amount of these people would have to be weighed versus the potential harm. He felt he would be a better diagnostician than any optometrist can ever be no matter what he uses because of the fact that he treats disease.

Don Hill, Attorney at Law, spoke in opposition to AB 580. He spoke on what the history has been in this type of legilsation and referred to Page 55 in Exhibit H. He said he had never found a law in which optometrists had been permitted to use drugs. Senator Blakemore brought out the fact that these drugs had never been considered dangerous so the optometrists had never been prohibited from using them. Mr. Hill also referred to Pages 59, 60, 61 and 62 in Exhibit I.

Dr. Polse rebutted one of two basic statements. With or without drugs, optometrists in this state are charged with the responsibility of recognizing disease or abnormal states of the eye and referring those patients to ophthalmologists or other physicians for prompt medical care. He said AB 580 would allow optometrists to recognize more trouble and get it referred. He pointed out that the California State Board of Medical Examiners worked with the California Optometry Board to establish the rules and regulations for the drug list which was established and the educational requirements. He said the California statutes puts the responsibility on the optometrist to recognize disease and refer the patient to an ophthalmologist.

Marvin Sedway, O.D., and also on the Nevada State Board of Optometry, spoke on AB 580. He said that optometrists in the State of Nevada do not pretend to be physicians; they do not intend to treat or use these diagnostic pharmaceutical agents in a therapeutic manner. If this bill becomes law, the Optometrists Board will be on guard to protect the public and will not allow the therapeutic use of any diagnostic pharmaceutical agent for any therapeutic purpose whatsoever. Their main concern is the protection and the benefit of the people in the state.

George Bennett, secretary of the State Board of Pharmacy, spoke on AB 580. He said that in 1971 the controlled substance act was introduced in Nevada, but it wasn't until 1973 that optometrists were excluded from being authorized to administer or dispense drugs. No one had any idea, until the complaint, that optometrists were using diagnostic prescription drugs that they were prohibited from using.

Senator Close asked why miotics were not allowed in some states where other topical drugs are allowed. Mr. Bennett said that miotics are primarily used for the treatment of glaucoma.

Richard Bjur, pharmacologist, said the question of whether pilocarpine counteracts the mydriatics or cycloplegics, pilocarpine acts as a specific inhibitor of an enzyme that breaks down the nerve transmitter that causes muscles to contract.

Senator Young asked if there was any harm done by using pilocarpine. Mr. Bjur said it depends on the dosage, circumstances and the way that it was administered which is a clinical decision. He personally did not see a great deal of good.

Dr. Curry said that for the record he had the definitions of the optometrists which were in the HEW report that were asked for and which he submitted (Exhibit O). He also submitted a copy of the California bill which did not include miotics in it (Exhibit P) and a list of specific drugs and concentrations (Exhibit Q) for consideration for amendments.

Senator Hernstadt asked how Dr. Curry's group wanted this bill to be dispensed. Dr. Curry replied he thought his group would like the bill killed or secondly, they would like it to be modified.

The hearing was closed on AB 580.

There being no further business, the meeting was adjourned at 5:00 p.m.

Respectfully submitted,

Betty L Kalicki

Betty Kalicki, Secretary

APPROVED:

Thomas R.C. Wilson, Chairman

SENATE Commerce and Labor COMMITTEE

GUEST LIST

DATE: Wednesday, April 25, 1979

NAME	AGENCY OR ORGANIZATION
Jan Hill	OPTHALMOLOGY
Wesley T. McCoy	Washoe County Medical Society
Helen Ellis	Nevada Eye Care
A. Curry M.D.	Ophthalmologist
Neil Sussman M.D.	Nevada Med Assn
M. Cocchi, M.D.	Ophthalmologist.
R. Moore MD	ophthalmologist
J. Bryant M.D.	ophthalmologist
J. Cupp OD	Optometrist
Ken Cole	Optometrist
Scott Frances	Pharmacologist
Richard Hagging	optometrist
Bill VanPatten	optometrist
Richard Bain	Pharmacologist
M. S. Pearlman	Las Vegas Ophth Society
D. Smallwith	optometrist
Marvin A Sedway	Optometrist - Nev State Board of Optometry

Library Note:

During the examination of this set of minutes, Exhibits A and B were found to be missing. The exhibits are also missing from the microfiche.

Research Library
August 2010

Exhibit C

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
WASHINGTON, D.C. 20310

REPLY TO ATTENTION OF:
DASG-PSC-O

18 OCT 1978

William Van Patten, O.D.
President, Nevada Optometric Association
1200 N. Mountain Street
Carson City, NV 89701

Dear Doctor Van Patten:

This is in response to your letter of October 9, 1978 requesting information concerning the use of diagnostic drugs in the Army.

Military optometrists have historically used various ocular diagnostic drugs in performing physical and tonometric examinations, and for disease detection. The use of these drugs by military optometrists is based on administrative and regulatory requirements.

The current policy concerning Army Optometrists states:

"Army optometrists provide optometric patient services in accordance with accepted medical guidelines. They examine the eyes and adnexa, to include refraction and other procedures, prescribe lenses to correct refractive error and improve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. They use topical anesthetics and cycloplegic drugs to perform tonometry and cycloplegic refractions. When using these drugs immediate medical care is available in the event of adverse reaction."

A search of the Army's computerized data system for CY 1977 has indicated that there were no recorded admissions to Army Treatment Facilities due to adverse reactions to ocular drugs. Data for prior years or the current year are not available.

EXHIBIT C

DASG-PSC-O
William Van Patten, O.D.

According to the US Army Claims Agency, there is no record of any malpractice claims ever processed pertaining to the improper use of drugs by Army Optometrists.

I trust this information has been helpful to you.

Sincerely,

Arthur R. Giroux

ARTHUR R. GIROUX, O.D.
Colonel, MSC
Chief, Optometry Section
Medical Service Corps

FILE MD. T

Exhibit D

THE UNIVERSITY OF KANSAS MEDICAL CENTER
COLLEGE OF HEALTH SCIENCES AND HOSPITAL
RAINBOW BOULEVARD AT 39TH • KANSAS CITY, KANSAS 66103

SCHOOL OF MEDICINE
SCHOOL OF NURSING
SCHOOL OF ALLIED HEALTH
UNIVERSITY HOSPITAL

DEPARTMENT OF OPHTHALMOLOGY
(913) 588 6600

August 24, 1977

Mr. Larry Zupan, Executive Secretary
American Association of Ophthalmology
1100--17th Street, Northwest
Washington, D. C. 20036

Dear Larry:

As I wrote you several weeks ago we are going to have a Continuing Education Course for primary care physicians and optometrists here at the University of Kansas Medical Center. I promised I would send you the manual that the registrants would receive at the course. Enclosed is the final product. I wanted to be certain that you and the AAO know just what is being presented because I am rather tired of wild rumors. I would appreciate any comments that you or others have on the goal and the material presented at this course.

I hope all is well with you and will look you up at the Academy in Dallas.

Sincerely,

Albert N. Lemoine, M. D.
Professor and Chairman

ANL:jc

Enclosure

use for "mandatory referral" basis!

EXHIBIT D

SUMMARY

Albert N. Lemoine, M. D., F.A.C.S.

There are ocular complaints obtained in the history and findings during an ocular examination that almost without exception are an indication for referral to an ophthalmologist for definitive diagnosis and therapy.

HISTORY

1. Rapid visual loss - over a period of minutes or hours.
2. Episodes of intermittent periods of reduced vision.
3. Sudden onset of "floating spots" in the field of vision.
4. Flashes of light in the visual field.
5. Defects in the field of vision, scotomas.
6. Distortion of objects or lines.
7. Rapid onset of visual haze with no specific complaint of decreased visual acuity.
8. Severe pain around the orbit or in the eye.
9. Prolonged severe pain in the occipital area.
10. Diplopia or visual confusion.

CLINICAL FINDINGS

1. Best corrected visual acuity 20/40 or less, unless they have had a prior diagnosis by an ophthalmologist.
2. Any patient whose refractive error changes one half a diopter or more, especially on the hyperopic side, within ninety days except for children with myopia.
3. Masses of the lids or adnexa either with or without inflammatory signs.
4. Defects in the lid margin.
5. Redness that is most marked in the 2 mm. zone adjacent to the cornea.
6. Any type of corneal clouding or infiltration either with or without congestion of the conjunctiva.
7. Cloudy anterior chamber.
8. Blood in the anterior chamber.
9. Small, poorly or nonreactive pupil.
10. Dilated, poorly or nonreactive pupil.
11. White pupil reflex.
12. Cataracts or lens opacities before the visual acuity is reduced to 20/40 or less.
13. Vitreous "floaters".
14. Blood in the vitreous.
15. Papilledema.

16. Optic atrophy, primary or secondary.
17. Larger or smaller than normal disc.
18. Abnormal disc cupping.
19. Dilated veins with or without retinal hemorrhage.
20. Narrowed arteries with or without retinal hemorrhage.
21. Any masses seen in the fundus, pigmented or nonpigmented.
22. Retinal hemorrhages, one or both eyes.
23. Pigment disturbance, either increase in pigment or decrease other than the dark fundus of the black race or lack of pigment in blond or albino patients.
24. Any areas of retinal elevation.
25. Retinal tears.
26. Presence of diplopia.
27. Nystagmus.
28. Scotoma.
29. Distortion of lines Amsler Grid or objects.
30. Any visual field defect other than blind spot.
31. Ptosis.
32. Intraocular tension of 22 or more on two or more occasions.
33. Exophthalmos, unilateral or bilateral.

over 10 D myopia

OCULAR EXAMINATION DRUGS

TYPE	PURPOSE	ADVANTAGES
CORNEAL ANESTHETIC	TO DENSENSITIZE THE CORNEA FOR PURPOSE OF MEASURING PRESSURE WITHIN THE EYE. TO USE SPECIAL CONTACT LENSES FOR EXAMINATION OF THE EYE.	ABLE TO ESTABLISH ABNORMAL EYE PRESSURE, EXPECIALLY HIGH PRESSURE, USING INSTRUMENT(S) OF CHOICE FOR PREVENTION OF PRESSURE-INDUCED LOSS OF VISION (GLAUCOMA).
MYDRIATIC	TO ENLARGE THE EYE PUPIL FOR EASIER AND MORE COMPLETE EXAMINATION OF THE EYE.	ALLOWS BETTER VIEWING OF EYE INTERIOR FOR PERSONS WITH SMALL PUPILS AND PERMITS MORE PERIPHERAL VIEWING OF RETINA FOR ALL PATIENTS--ALLOWING EARLIER DETECTION OF DISEASE PROCESSES LEADING TO LOSS OF SIGHT.
CYCLOPLEGICS	TO ENLARGE THE EYE PUPIL (FOR REASONS CITED ABOVE) IN PERSONS WHOSE PUPILS ARE RESISTANT TO DILATION BY MYDRIATICS, AND TO IMMOBILIZE ACCOMMODATION.	ALLOWS BETTER VIEWING OF EYE INTERIOR (FOR REASONS CITED ABOVE) AND PERMITS UNCOVERING OF FARSIGHTEDNESS, ESPECIALLY WHEN ASSOCIATED WITH "EYE TURN".
MIOTICS	TO COUNTERACT EFFECTS OF MYDRIATIC DRUG TO TEST FOR CERTAIN TYPES OF PUPIL ABNORMALITIES.	ALLOWS FOR FAST PUPIL "RECOVERY", IF NEEDED ALLOWS FOR ACCURATE DIAGNOSIS OF CERTAIN PUPIL ABNORMALITIES.

Exhibit F

HARRIE F. HESS, PH.D., LTD.
DIPLOMATE IN CLINICAL PSYCHOLOGY
4055 SO. SPENCER, SUITE 216
LAS VEGAS, NEVADA 89109

April 24, 1979

Marvin Sedway, O.D.
3201 S. Maryland Parkway
Las Vegas, Nevada

Dear Dr. Sedway:

I wonder if you would be so kind as to give me some information regarding a professional matter, and to solve what appears to me to be a contradiction. My daughter is under the care of an opthalomogist for progressive juvenile myopia. The opthalomogist has prescribed bifocals and atropine drops to be administered every other day. Now my question is, would you consider this the appropriate treatment for the condition? Secondly, with regard to the apparent contradiction: the opthalomogist has said that we, as parents, should administer the drops every other day for more than a year. I don't understand this, in view of the fact that I have been reading in the papers that the opthalomogists are complaining that even optometrists, who have taken relevant courses, cannot safely administer the atropine, even for a single examination. I don't understand how I, as a parent of the child, am more qualified to administer the atropine than an optometrist. Please explain. Thanks.

Sincerely,

Harrie F. Hess

HFH:ca

Exhibit G

STATE OF NEVADA

TESTIMONY AB580

My name is Richard L. Hopping, O.D. I am President of Southern California College of Optometry. I appear on behalf of AB580 as a representative of optometric education and as President of the third oldest optometric educational institution in the nation. The institution I represent is the Southern California College of Optometry. We have been a supplier of optometric manpower for the State of Nevada for many years. Of the nation's 13 optometric colleges, I can relate that they are all fully accredited by the appropriate regional accreditation agency, as well as the professional accrediting body, the Council on Optometric Education. This body receives its authority from the Council on Postsecondary Accrediting which is the same authority that grants accreditation for the professions of medicine, dentistry, law, veterinary medicine, etc.

Applicant demand this past decade for admission into optometry is at such a high level that the non-duplicate ratio of applicant to acceptance is only exceeded by the profession of veterinary medicine. For over a decade at my institution the mean class average completed by the entering class is 4½ years of the pre-optometric undergraduate education prior to admission to the four-year professional optometric curriculum.

Our new campus and a considerable part of our annual operations income comes by way of the Health Professional Educational Assistance Act; an act signed into law in 1962 provides Federal

funding for the independent health professions whose services are deemed important to the health care of the American people.

Our faculty is composed of recognized authorities in various disciplines--anatomists teach anatomy, physiologists teach physiology, pathologists teach pathology, pharmacologists teach pharmacology, optometrists teach optometry, ophthalmologists teach ocular disease. Some five or six of our faculty also hold joint appointments in several of the local medical schools in the University of California system.

The clinical program in optometry is analogous to the training provided in dentistry and podiatric medicine. In the institution I represent students commence their clinical training in their second year. My institution operates a total of 28 clinical programs in five states. Our private clinics in California are licensed as community clinics by the Department of Public Health and the State of California. Our other clinics are operated in conjunction with such agencies as the San Gabriel Valley Regional Health Service, Los Angeles County Department of Health Services, U.S. Public Health Serivce, Indian Health Service, Veterans Administration Hospital, V.A. Outpatient Clinic, Pacific State Hospital and various clinics in the four branches of the military service. Our institution has affiliations with some six hospitals, thirteen medical centers, as well as a number of other group and multidisciplinary clinics. For over 3 years the College has conducted a Low Vision Clinic in conjunction with the Bureau of Services to the Blind, Nevada Department of Rehabilitation. Our students receive a wide range of clinical experiences with a range of

patients from new borns in a children's hospital to geriatrics in convalescent and V.A. hospitals. They provide care to patients from various socio-economic and ethnic backgrounds. Our clinical programs are designed to provide students with experience in a variety of health care delivery systems.

Pharmaceutical agents for diagnostic purposes are utilized in the clinical programs of all of the optometric institutions. Our graduates are qualified and prepared, as well as expecting to utilize PA upon their graduation.

Optometry is the nation's third largest independent health profession. We are educated and licensed to practice our own profession. Optometrists are not physicians, nor dentists, nor podiatrists; we are optometrists. Our education is one of quality. We are not attempting to imitate a physician, nor practice medicine any more than the dentist or the podiatrist does. Some medical specialists blur the issue by attempting to relate our scope of training, etc. in terms of a physician. This is no more fair than to state that physicians or dentists are non optometric, and to relate how their education and skill is inferior in some ways to that of the optometrist. If optometrists were not uniquely different in education, responsibility, and service, then distinct professions were and are not needed. It is for this reason that the profession of optometry does desire to use pharmaceutical agents topically, not orally or intravenously. The concentrations of the agents proposed to be utilized by optometrists are considerably different as is the purpose. Nevada Optometry in their pursuit of excellence desires the use of such topical agents

EXHIBIT G - J

for the purpose of enhancing their diagnostic optometric examination procedures so that they may continue to render an even finer quality of vision care to people of the State of Nevada.

As an optometric educator, I respectfully urge your support of AB580 with every confidence that the people of Nevada will be safe and yet better served.

Exhibit H

REFERENCE MATERIAL

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY

MANUAL

For Use of Topical Pharmaceutical Agents

1/79

17.0 Topical Pharmaceutical Agents Manual (1/79)

INTRODUCTION

The purpose for this manual is to provide guidelines for use of topical pharmaceutical agents in all of the optometry training programs of the Southern California College of Optometry.

The procedures, as set forth, should help to achieve the following:

1. The application of didactic knowledge gained in general and ocular pharmacology courses to a clinic setting.

2. To enhance the scope of professional optometric diagnostic services rendered to patients by the utilization of pharmaceutical agents in such procedures as tonometry, funduscopy, gonioscopy, and cycloplegic refraction, when any of these techniques are deemed appropriate in the examination and diagnosis of conditions of the visual system of a patient.

3. The optometric clinical faculty and students of the College are specifically restricted to the use of pharmaceutical agents currently provided by the California Optometry law as listed and described in this manual. Under no circumstances shall any of these agents be used or prescribed for therapeutic purposes.

4. The College's faculty engaged in the supervision and/or use of pharmaceutical agents must have presented satisfactory evidence that their educational background in didactic and clinical pharmacology satisifes the requirements of the California Optometry law.

5. The use of topical pharmaceutical agents is specifically limited to the faculty and students of the professional program.

   Technician students, in accordance with the California Optometry law, are prohibited from the use of topical pharmaceutical agents.

6. Approved pharmaceutical agents will be properly stored in each clinic and/or module. They will be supplied to the clinician administering the drug(s) by the supervising faculty member and must be returned to the faculty member immediately after use.

7. Each clinician is expected to inform the patient and/or guardian of any possible side effects that may occur from the instillation of the topical pharmaceutical agent(s) which are to be utilized.

Protocol Preliminary to the Usage of a Mydriatic or Cycloplegic Agent

Prior to a dilated fundus examination or a cycloplegic refraction all patients shall have the following procedures completed:

1. Case History including:

    a. Systemic health history
    b. Ocular health history
    c. Drug history (past and present)

2. Basic Visual Examination including:

    a. Visual acuity
    b. Pupillary reflex evaluation
    c. Refraction and phorometry
    d. Ophthalmoscopy
    e. Sphygmomanometry
    f. Visual field screening
    g. Biomicroscopy
    h. Chamber-depth evaluation
    i. Tonometry
    j. Gonioscopy (when indicated)
    k. Visual Fields (when indicated)

3. Potentially occludable angles will <u>not</u> be dilated.

4. All patients to be dilated will have the procedure fully explained and advised to have another person provide transportation following the examination. Patients should be advised that following dilation they may experience temporary inconvenience; i.e., blurred vision, photophobia. Temporary dark lenses should be provided to all patients who did not bring their own.

Protocol Preliminary to the Usage of Local Anesthetics

Prior to the usage of a local anesthetic all patients shall have the following procedures completed:

1. Case history including:

    a. Systemic health history
    b. Ocular health history
    c. Drug history (past and present)

2. Clinical procedures:

    a. Visual acuity
    b. Biomicroscopy

If patient discomfort precludes performing the above clinical procedures prior to the instillation of a local anesthetic, they shall be attempted immediately after the instillation of the drug.

Procedure for Dilated Fundus Examination

1. Student clinicians will only administer drugs under the direct supervision of a clinical faculty member.

2. Written orders by a clinical faculty member are required prior to the instillation of any drug. Such written orders shall include drug name, concentration, amount, frequency and interval of instillation.

3. Where indicated one drop of a topical anesthetic may be instilled prior to the mydriatic agent. Care should be taken to insure that the patient does not rub his eyes following instillation of the anesthetic.

4. As standard clinic procedure, each eye will have one drop of tropicamide 0.5% or 1% instilled.

5. After 15 minutes, if needed, orders may be written for additional instillation of one drop of phenylephrine 2.5% or one drop of hydroxyamphetamine 1% or an additional drop of tropicamide 0.5% or 1% instilled.

6. Twenty minutes following the last instillation, the patient will be examined. After the use of a sympathomimetic, sphygmomanometry will again be completed before the patient is dismissed.

7. Any unusual or adverse reactions observed must be fully recorded and reported to the clinical faculty member under whose supervision the drug was instilled.

Procedure for Cycloplegic Examination

1. Student clinicians will only administer drugs under the direct supervision of a clinical faculty member.

2. Written orders by a clinical faculty member are required prior to the instillation of any drug. Such written orders shall include drug name, concentration, amount, frequency and interval of instillation.

3. Where indicated, one drop of a topical anesthetic may be instilled prior to the cycloplegic agent. Care should be taken to insure that the patient does not rub his eyes following instillation of the anesthetic.

4. As standard clinic procedure, each eye will have one drop of cyclopentolate 0.5% or 1% instilled. After 15-20 minutes an additional drop may be instilled. Forty-five minutes after the initial instillation, the patient will be examined.

5. In instances where tropicamide is indicated, one drop of 1% solution is to be instilled in each eye and repeated five minutes later. Twenty minutes after the initial instillation the patient will be examined.

6. Any unusual or adverse reactions observed must be fully recorded and reported to the clinical faculty member under whose supervision the drug is instilled.

Approved Topical Pharmaceutical Agents

Agent	Maximum Allowed Concentration
Topical Anesthetics:	Proparacaine HCl 0.5% (Ophthetic®; Alcaine®)
	Benoxinate HCl 0.4% (Dorsacaine®; Fluress®)
	Piperocaine 2% (Metycaine®)
Mydriatics	Phenylephrine HCl 2.5% (Efricel®; Neosynephrine®)
	Hydroxyamphetamine 1% (Paredrine®)
Cycloplegic Mydriatics:	Tropicamide 1% (Mydriacyl®)
	Cyclopentolate 1% (Cyclogyl®)
	Atropine Sulfate 0.5% (ointment only)

Indications for the use of Topical Pharmaceutical Agents

A. Mydriatics

1. Where there is impediment to normal view of posterior segment of eye; i.e.:

    a. Miotic pupils
    b. Media opacities which reduce fundus view
    c. Poor patient fixation; i.e., nystagmus

2. Where a larger field of view is desired

    a. All myopes over 5.00D
    b. Unexplained reduced best corrected visual acuity
    c. Aphakic patients (except implants)
    d. Diabetic patients
    e. Patients with any fundus lesion
    f. Monocular individuals
    g. Symptoms:

        1. Flashes of light
        2. Significant changes in floaters
        3. Symptoms of retinal detachment

    h. Persons with recent history of head trauma
    i. Elevated pressure or suspected glaucoma where angle is open
    j. Fundus or anterior segment photography
    k. Visual field defects

B. Topical anesthetics

1. Tonometry
2. Gonioscopy
3. Inspection of traumatized eye
4. Pre-cycloplegic or mydriatic
5. Schirmer tear test #2
6. Contact Hruby lens evaluation
7. Scleral depression
8. Electro-retinograms

C. Cycloplegics (predominantly with children)

1. Inadequate subjective response
2. Refractive errors

    a. Large astigmatic errors
    b. High hyperopia
    c. Suspected latent hyperopia
    d. Anisometropia

3. Strabismus
4. Major change in refractive error occurring

D. Possible contraindications for use of topical anesthetics

1. Corneal damage
2. Allergies
3. Hypersensitivity
4. Emotional instability

E. Possible contraindications for use of topical mydriatics and cycloplegics*

1. Narrow angle
2. Diabetes
3. Hypertension
4. Corneal damage
5. Allergies
6. Patient taking Monoamine Oxidase (MAO) inhibitor type of antidepressants
7. Hyperthyroidism
8. Down's syndrome
9. Minimal brain dysfunction
10. Hyperactive children
11. Hypersensitivity
12. Driving motor vehicle
13. Emotional instability

*Under no circumstance shall a person with an intraocular lens implant have a mydriatic or cycloplegic agent instilled.

EXHIBIT H

HEALTH AND DRUG HISTORY

PATIENT'S NAME _____ DATE _____ SEX M F DOB _____

GENERAL HEALTH: _____ EXCELLENT _____ GOOD _____ FAIR _____ POOR

Last complete physical examination _____ Last physician visit _____

Has the patient seen a physician for: (circle below)

1. headaches
2. allergies
3. asthma
4. hypertension
5. diabetes
6. kidney disease
7. cataracts
8. glaucoma
9. insomnia
10. epilepsy
11. parkinsonism
12. hormonal
13. thyroid disease
14. cancer or tumors
15. emotional
16. ulcer
17. pain

Additional Comments: _____

Any family history of: (circle below) Who? _____

1. glaucoma
2. cataracts
3. hypertension
4. diabetes
5. thyroid disease
6. allergies

Has the patient ever had any adverse drug reaction? ____yes _____no

List drug and reaction:

List current medications (Rx & O.T.C.)	How Long?	How Many?	How Often
1.			
2.			
3.			
4.			
5.			

OCULAR HEALTH:

Last complete eye exam _____ Iris Color _____

Has the patient ever had eye surgery? ___Yes ___No Nature _____
Does the patient have an intraocular lens implant? ____Yes ___No
Has the patient ever had an eye injury? ___Yes ___No Nature _____

Do you ever experience: (Give details)

1. Blur
2. Double Vision
3. Vision Loss
4. Headaches
5. Pain in Eye
6. Redness
7. Excess Tearing
8. Dry Eyes

Do you wear contact lenses? ___Yes ___No

PHARMACEUTICAL AGENT RECORD

	Date	Drug	Conc.	Drops	Angle	I.O.T.	Faculty Approval	Instilled by	Time of instill.
1.									
2.									
3.									
4.									
5.									
6.									

TESTIMONY AGAINST AB 580

TABLE OF CONTENTS

EXHIBIT I

When carefully examined, A.B. 580 contains ammendments to N.R.S. 636 which make this one of the most dangerous bills to surface in this or any session of the Nevada Legislature -- a bill which threatens not only the eyes but the actual health and safety of every citizen of Nevada.

EXHIBIT I - J

Contrary to what optometrists would like you to believe, A.B. 580 isn't concerned with simple "eye drops." The "diagnostic pharmaceutical agents" referred to in A.B. 580 are prescription drugs -- drugs with the power to cause illness, injury, and sometimes death, even though they're only administered to the eyes.

TAB I

EXHIBIT I

RENO GAZETTE/JOURNAL

Eye care bill

A dispute is brewing in the Legislature over a bill which would allow optometrists to use "diagnostic drugs" in eye examinations.

The bill is pitting Nevada's optometrists — who perscribe and fit lenses — and opthalmologists — physicians who diagnose and treat eye diseases — against each other.

Most of the time, the two groups enjoy a symbiotic relationship. They aid and refer patients to each other, and in most areas of discussion, agree. But when it comes to the use of drugs in eye exams, they are in sharp conflict.

Nevada's optometrists are participating in a nationwide push to obtain legislation permitting them the use of several drugs which would allow them to look into the eye and spot special problems. They say they have proper training in pharmacology to use the drugs, and can provide better eye care to patients who often see them in lieu of an opthalmologist. Adverse reactions to such drugs are extremely rare, and do not merit keeping them out of the hands of trained optometrists.

But the opthalmologists disagree. They say drug reactions are not as rare as optometrists say. Although they agree adverse reactions are unusual, they have the potential for causing blindness and in extreme cases, death. Optometrists, they say, do not have enough medical training to handle reactions which can also include possible heart and respiratory problems and convulsions. And finally, optometrists have sufficient technology and skills to do good eye exams without using potentially hazardous drugs.

The bill also is being pushed as a consumer-oriented bill, which would improve the quality of eye care while helping to keep costs to the client down. Again, the opthalmologists disagree. They say exam rates are virtually the same in Nevada between the two groups.

While we are in favor of keeping health care costs down, we must side with the opthalmologists on this issue, and hope that the Assembly does not pass AB 580.

The Nevada State Board of Medical Examiners says it believes passage of the bill "would be detrimental to the health and welfare of our citizens to permit optometrists to perform such medical functions." We agree.

EXHIBIT 1

R-J Viewpoint

The 'eyes' have it in the Legislature

The "eyes" have it.

One of the hottest items being lobbied these days in the Legislature concerns two bills dealing with the care and treatment of eyes.

Assembly Bill 580 permits optometrists to use certain prescription drugs for the purpose of making examinations, provided they complete courses in eye care pharmacology.

These drugs have been reserved for use by opthalmologists who, unlike optometrists, are medical doctors. Naturally, the opthalmologists are opposed to the bill.

They feel, and we must agree, that the optometrist — even with the added course in pharmacology — is not suited to administer potentially dangerous drugs.

We have talked to both sides on the issue, and we feel that the medically trained doctor, not optometrist, should treat the eye patient.

The slightest misuse of these drugs can cause a number of major problems, such as heart trouble and damage to the entire nervous system. We feel optometrists should stick with fitting glasses and testing depth perception, eye focus and coordination, but they should stay away from medical diagnostic functions reserved for trained medical doctors.

Another piece of legislation, Senate Bill 10, deals with department stores, such as Sears and J.C. Penney, having complete facilities to examine patients to determine if they need glasses.

A source in Carson City informs us that Assemblyman Dr. Bob Robinson, an optometrist, has this bill bottled up in committee. We hope this isn't true, because from what we have been told, having such eye centers in department stores would result in a savings to the public.

We think that tough lobbying in Carson City is something that goes with the territory. But we don't like to see it at the expense of someone's health or financial cost.

EXHIBIT

Wednesday, March 28, 1979

SUN

Editorial

A Concern For Health

There is a bill floating around in the Assembly Commerce Committee which is fraught with danger.

Assembly Bill No. 580 (AB-580) will allow optometrists to use diagnostic drugs in their practice.

An optometrist is not a medical doctor and therefore has no business using drugs without the approval of a medical doctor.

AB-580 is part of a nation-wide attempt to allow optometrists to practice medicine. An optometrist, in fact, is a limited practitioner, whose formal education limits him to testing for vision problems not related to disease. To overcome this shortcoming the bill in the legislature states they must complete "a course in general and ocular pharmacology." This is not sufficient and has been added in an effort to meet the legitimate complaints of medical people. It does not adequately meet these objections.

Confusing Arguments

The arguments over this bill may become confusing to the general public. During these debates some confusion will result from terminology. Let's clarify the difference between an optometrist and a medically trained eye doctor — an ophthalmologist.

The ophthalmologist, a true medical doctor, is qualified to provide comprehensive diagnostic eye examinations for both systematic and ocular diseases and the application of medical treatment including prescribing lenses and medication.

One Who Tests

The optometrist has a professional degree. He can test for non-disease related vision problems, test for depth and color perception, and test for the ability to focus and co-ordinate the eyes. He can also prescribe and fit lenses. He is a valuable member of any health care team. We just don't want him using drugs which may be dangerous in the hands of anyone other than a medical doctor.

AB-580 seeks to give optometrists the power to use diagnostic drugs for examinations: local anesthetics to aid in measuring pressure on the eye, mydriatics to make the pupil larger and give a better view of the eye's back wall, miotics to constrict the pupil after it has been dilated by mydriatics, and cycloplegics to eliminate muscular movements that can prevent thorough examinations.

Some of these drugs can be dangerous and affect the nervous system. An example of some of the drugs available for eye diagnosis are:

Some Drugs Used

Neosynephrine in 10 percent solution. This concentration is 80 times stronger than the neosynephrine solution used in nasal drops. It can cause a stroke if improperly used.

Phospholine iodide. This is a pupil-constricting agent, used in combination with the dilating drugs. Absorbed in the body, it can affect the enzyme system.

The opportunity to support a common position for the Southern Nevada Central Labor Council and the Nevada State Medical Association seldom arises. Common opposition to AB-580 is one time we believe both are right on target.

The SUN requests strong legislative opposition to AB-580 for protection of our citizens' health. Any legislator supporting this bill is either ignorant or has sold out to interests not concerned with the good health of our people.

TAB II
EXHIBIT 1

MISLEADING STATEMENT:

"Optometrists need the drugs requested to help diagnose eye disease so that proper referrals can be made."

REBUTTAL:

1. Optometrists are not trained - or required - to "diagnose" eye diseases. Diagnosis is a medical function.

2. Drugs are not needed to detect the usual reasons for referral, namely:

-poor uncorrectable vision
-a painful or inflamed eye
-glaucoma or high eye pressure

3. It is unnecessary to allow optometrists to use drugs to "open" the eye so they can look for what they are not trained to recognize.

MISLEADING STATEMENT:

"Optometrists have been using drugs in this state for years without harm or death to anyone."

REBUTTAL:

1. If this is indeed the case, optometrists have willfully violated both the Medical Practices Act and the Pharmacy Act of Nevada.

2. Such use would have been illegal and surreptitious. Any injurious consequences would have been unreported and therefore unknown to public authorities.

EXHIBIT I

MISLEADING STATEMENT:

"The drugs optometrists propose to use are harmless and medical opposition to such use is 'hysterical.'"

REBUTTAL:

1. This statement emphasizes the innocence or ignorance of those who make it. No drug is truly harmless, as the wise and cautious physician knows.

2. Special medical and physical conditions as well as drug allergies, drug side effects, and drug idiosyncracies all can cause unexpected drug reactions.

3. To deal with unexpected drug reactions, a physician needs in his office:

-oxygen	-vasopressors
-stethescope	-steroids
-sphygmomanometer	-adrenalin
-stimulants	-xylocaine
-syringe and needles	-buffering agents

We submit that optometrists don't have these modalities, nor do they know how and when to use them.

MISLEADING STATEMENT:

"Dangers of eye damage or death from the use of diagnostic eye drugs is exaggerated. There are no reports of such occurrences."

REBUTTAL:

1. The following excerpt is from the article "Optometry Drug Laws," published in the Loyola Law Review, Loyola University Press, Vol 24/1978, p. 225:

"Physicians stress that although side effects and reactions from the drugs contemplated in the [optometric drug] statutes are rare, they can be quite severe and in fact can cause blindness and death."

2. The following summary is taken from the report of F.T. Fraunfelder, M.D., and Arnauld F. Scafidi, M.D., which was issued in consequence of a study funded by the U.S. Food and Drug Administration, Contract #223-76-3018:

"Based on case reports submitted to the National Registry of Drug-Induced Ocular Side Effects, 27 cases of adverse side effects possibly related to ocular 10% phenylephrine application are summarized. These cases include 12 myocardial infarcts, 9 of which were terminal, 6 additional cases requiring cardiopulmonary resuscitation, and the remainder primarily marked elevation of blood pressure . . . Possible guidelines for the use of 10% phenylephrine hydrochloride are suggested."

(Emphasis added)

EXHIBIT 1

MISLEADING STATEMENT:

"Nurses, dentists, podiatrists, and paramedics can use drugs; optometrists should be allowed to do so too."

REBUTTAL:

1. Dentists, podiatrists (and veterinarians) are healing professionals who are trained in hospitals and clinics. Optometrists are not.

2. Nurses, and paramedics only administer drugs under orders or supervision of physicians.

MISLEADING COMPANION STATEMENT:

"Optometrists are allowed to use drugs in the U.S. military services."

REBUTTAL:

The following is the official policy of all three military Surgeons General on this matter:

> "The optometric clinic provides optometric patient services under medical supervision. Optometrists examine the eyes and adnexa to include refraction and other procedures, prescribe lenses to correct refractive errors and improve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. Optometrists use appropriate drugs to perform optometric procedures. When using these drugs, immediate medical care is available in the event of adverse reactions."

From the tri-service policy of the U.S. Department of Defense, as quoted in The Pen, Oct. 1, 1977, page 1, col. 3. (Emphasis added)

EXHIBIT I

MISLEADING STATEMENT:

"Optometrists are qualified to administer some eye drugs."

REBUTTAL:

1. This statement contains a self-given accolade without a generally recognized academic basis.

2. The optometrist's training and clinical experience does not prepare him for intelligent and safe use of drugs. Further, the limited testing and examination provisions of the proposed legislation cannot create skills which simply do not exist. The proposed legislation calls for certain courses to be taken by an optometrist before he can be certified in Nevada to utilize diagnostic drugs. However, pathology and pharmacology cannot be learned from textbooks, lectures, and movies alone. Basic classroom and laboratory instruction in pharmacology are merely an introduction to principles. This knowledge must be built on a broad background of basic scientific training coupled with intensive, direct treatment of patients in hospitals and clinics. It is precisely this clinical training which the optometrist lacks.

EXHIBIT 1

MISLEADING STATEMENT:

"Optometrists want only to redefine the Optometric Practices Act."

CORRECTION:

1. In testimony before the Virginia Optometric Association on May 2, 1977, Robert M. Greenburg, O.D., stated:

"Implicit in the decision to use drugs is a major change in the scope and definition of optometric practice."

(The Pen, Oct. 1, 1977, pg. 4, col. 2)

2. The aim of the optometric profession was suscinctly expressed by the President of New York's College of Optometry in the November, 1977, issue of Consumer Reports, as follows:

"Optometrists will eventually handle examinations, diagnosis, and treatment up to the point of surgery."

3. With the requested "redefinition" of the Optometric Practices Act, optometrists are actually seeking to enter the medical profession by an act of law, rather than by virtue of training which would qualify them medically.

4. The examples of West Virginia and North Carolina substantiate this argument: in these states, optometric practices acts have been redefined to include drug use for therapeutic as well as diagnostic purposes.

5. This redefinition attempt extends to recent advertisements by the American Optometric Association in national magazines and on t.v.; these promote public misunderstanding that complete medical care has been effected after an optometric examination.

EXHIBIT I

MISLEADING STATEMENT:

"The optometric drug use controversy is mainly an economic issue between the medical and optometric professions."

REBUTTAL:

1. No monetary gain or loss will ensue to eye physicians if optometrists use eye drops and make proper referrals for problem cases.

2. The economic motive in this matter is optometry's ultimate aim to become the PRIMARY CLEARING HOUSE AND REFERRAL SOURCE for all people needing eye services. This would mean great economic gain to optometrists by virtue of increased patient traffic.-- with a fee being incurred for all such transactions.

EXHIBIT I

MISLEADING STATEMENT:

"Optometric drug use is a national trend; more and more states are allowing it."

REBUTTAL:

1. Early approval of optometric drug use laws in 14 states was primarily the result public ignorance in the face of deceptive arguments and misinformation about the "benefits" of optometric drug use. The medical profession was caught napping and failed to alert the public and lawmakers about the dangers of such laws in time to keep them from being passed.

2. In 1978, because of more open debate and increased public awareness, 15 out of 17 states refused passage of optometric drug laws. In 13 states drug use proposals failed to pass; in 2 states (Virginia and Ohio), conscientious governors vetoed the measures.

3. Today, a rash of new optometric drug bills are being introduced around the country, and optometrists are frantically lobbying lawmakers to pass them. At the same time, however, efforts to repeal optometric drug use laws are underway in Louisiana, West Virginia, and North Carolina.

Optometrists are called "doctors," but they are not medical doctors or eye physicians. Their use of the title "Doctor" is like that of a minister (Doctor of Divinity) or a teacher (Doctor of Philosophy). Optometry is a measuring science, not a healing science. An optometrist hasn't completed the years of training that a physician has; he isn't allowed to "heal" a patient's disorders in the way that a physician is -- by prescribing drugs and performing surgery. And optometrists in Nevada have never before been specifically empowered to administer drugs.

SOME BASIC DEFINITIONS

OPTOMETRY: A measuring science (from OPTO - "to see" + METER - "to measure") to test and evaluate visual functions such as visual acuity, depth and color perception, and the ability to focus and coordinate the eyes. Optometry is NOT a healing science or a medical science.

OPTOMETRIST: A licensed, non-medical practitioner educated and trained to practice optometry. He prescribes eye exercise and prescribes and sells glasses, prisms and contact lenses. His formal professional education usually includes 2 years of college and 4 years of optometric school and involves no hospital or medical clinic work. Upon graduation, he is granted a "Doctor of Optometry" degree, much as a minister is granted a "Doctor of Divinity" or a scholar is granted a "Doctor of Philosophy." An optometrist is NOT a medical doctor or eye physician: he is not trained to evaluate the eyes medically, "diagnose" eye diseases, or correlate his examination with the patient's health -- he is not qualified to make medical judgements concerning the eye or its relationship to the body.

OPTHALMOLOGIST: A physician and surgeon (medical doctor) who specializes in the diagnosis and treatment of eye diseases, defects, and disorders. He prescribes glasses and lenses to correct visual disorders; he also prescribes and administers drugs and performs delicate eye surgery. His formal professional education usually includes 4 years of college, 4 years of medical and clinical schooling, 1-2 years of medical/surgical intership in a hospital, and 3-4 years of special "residency" training

in an eye clinic and hospital, for a total of 12-14 years. This extensive medical background qualifies the opthalmologi to diagnose and treat eye disorders in relationship to the whole body and the patients's general health.

The Optometric Profession EXHIBIT 1

Monroe J. Hirsch & Ralph E. Wick

Chilton Book Company

Philadelphia, New York, London

QUOTES-----a text used in most, if not all, optometry schools

page 17----"The optometrist does not treat diseases of the eye and does not attempt to make difficult, definitive, differential diagnoses between two diseases."

page 18----"...he accepts the responsibility for referring those whose ailments are more complex or outside his realm."

page 20----"They do not attempt to complete a definitive diagnosis, recognizing that this is a part of of the practice of medicine."

AN OPTOMETRIST'S EDUCATION DOESN'T PREPARE HIM TO USE PRESCRIPTION DRUGS SAFELY

Optometric education generally includes two years of college and four years of training in a college of optometry. While recent graduates of optometric colleges may have had limited classroom exposure to pharmacology and pathology, most have received no hospital or medical clinical training, and thus have no experience in recognizing the onset of adverse reactions to the drugs they would be allowed to administer under AB 580.

Further, pharmacology and pathology have only recently been included in the course work required to obtain an optometric degree. The median age of optometrists in the United States is 49.4 years -- this means that 75% of all optometrists have received little or no exposure to pharmacology or pathology.

Proponents of AB 580 maintain that completion of "a course in general and ocular pharmacology" prior to certification to use pharmaceutical agents will adequately prepare optometrists to safely handle these toxic substances. No specific course length is actually even specified in the proposed bill, but 180 hours is frequently suggested as sufficient. 180 hours equals only about one month of training -- hardly an adequate substitute for the four to six years of post-graduate training required of physicians currently allowed to use prescription drugs in Nevada.

"The majority of the medical profession is unalterably opposed to the use of drugs by optometrists. The medical profession argues that the drugs involved have dangerous risks when used by someone without medical training and that an optometrist's training in pharmacology is not nearly enough to handle the use and side effects of the drugs." [1]

[1] "Optometric Drug Laws," Loyola Law Review, Vol. 24 / 1978, Loyola University Press, c. 1978, p. 224.

EXHIBIT 1

EYE CARE PRACTITIONERS

A COMPARISON OF EDUCATION AND PROFESSIONAL TRAINING

EYE CARE PHYSICIAN (OPTHALMOLOGIST)		OPTOMETRIST (NON-PHYSICIAN)	
Undergraduate College	4 years	Undergraduate College	2 years
Medical School	4 years	Optometric School	4 years
Medical/Surgical Hospital Internship	1-2 years	Medical/Surgical Hospital Internship	NONE
Eye Clinic/Hospital Residency	3-4 years	Eye Clinic/Hospital Residency	NONE
TOTAL	12-14 years	TOTAL	6 years

In addition to the different lengths of time spent preparing for eye-care practice, there is also a great difference between the types of training received; opthalmologists receive many hours of clinical instruction -- optometrists receive classroom education only. Further, opthalmologists are trained in pharmacology by M.D.'s -- most optometrists are not, as shown by the chart on the following page.

THE PEN...

WHO TEACHES OPTOMETRISTS MEDICINE?

CURRENT SCHOOL CATALOG STUDY COMPARES FACULTIES AT SEVERAL TYPICAL MEDICAL AND DENTAL SCHOOLS WITH FACULTIES AT ALL OPTOMETRY SCHOOLS IN THE U.S.

	Total = of Students	Total = of Faculty	Faculty Student Ratio	Total = of M.D. Professors (Full or Part Time)	Full Time Clinical* Teaching M.D. Specialists	OPHTHALMOLOGISTS (M.D. Eye Specialists)			PHARMACOLOGY DEPARTMENT		O.D.s	O.D./Ph.D.	Other Ph.D., M.S. or B.S.	COMMENTS
MEDICAL COLLEGES						Full Time	Part Time	M.D. Residents	M.D.s - M.D./Ph.D.	Ph.D., M.S. or B.S.				
Medical University of South Carolina College of Medicine	660	1,281	1.9	651	201	3	23	9**	6	25	0	0	630	* CLINICAL — Refers to working with patients in hospitals or out-patient clinics ** Ophthalmology Residents spend 3 months during their 3-year residency in an intense basic science course taught by nationally prominent Ophthalmologists at Colby College, Waterville, Maine
Duke University College of Medicine	489	1,102	2.3	632	483	8	10	16	2	7	0	0	470	
Medical College of Georgia	720	944	1.3	495	246	3	10	8**	2	10	0	0	449	
DENTAL COLLEGES														
Medical University of South Carolina College of Dentistry	160	312	2.0	74	0	0	0	0	6	25	0	0	123	84 D.D.S. teaching mostly Clinical 9 are D.D.S., Ph.D.
Medical College of Virginia College of Dentistry	439	353	.80	33	0	0	0	0	8	20	0	0	127	126 D.D.S. teaching mostly Clinical 20 are D.D.S., Ph.D.
COLLEGES OF OPTOMETRY														
Southern College of Optometry	604	49	.08	2 PART TIME	0	0	0	0	0	0	37	2	7	The 2 part time M.D.s are classroom lecturers in Pathology.
Illinois College of Optometry	600	56	.09	1 PART TIME	0	0	0	0	0	1	47	1	6	The only M.D. is a part time Lecturer in Pathology.
Pennsylvania College of Optometry	552	89	.16	5 PART TIME	0	0	2	0	0	1	55	4	17	
Southern California College of Optometry	384	83	.22	5 PART TIME	0	0	2	0	0	2	65	5	8	
Pacific University College of Optometry	340	23	.07	1 PART TIME	0	0	0	0	0	0	12	1	8	The only M.D. is a Professor of Physics and Optics, part time.
New England College of Optometry	332	66	.20	4 PART TIME	0	0	2	0	0	1	52	5	4	
University of Houston College of Optometry	284	64	.23	2 PART TIME	0	0	0	0	0	0	47	4	7	The 2 part time M.D.s are Classroom Lecturers in Pathology.
Indiana University College of Optometry	276	38	.14	0	0	0	0	0	0	0	21	4	11	No M.D.s on Staff.
Ohio State College of Optometry	228	63	.28	1 PART TIME	0	0	1	0	0	0	46	4	12	The only M.D. is part time. He lives 100 miles away in Cincinnati.
University of Alabama College of Optometry	160	48	.30	3 PART TIME	0	0	0	0	1	0	22	9	12	All M.D.s are part time classroom lecturers. One M.D./Ph.D. lectures in Pharmacology.
State University of New York College of Optometry	160	122	.76	9 PART TIME	0	0	6	0	0	0	87	3	22	
University of California Berkeley College of Optometry	256	77	.30	9 PART TIME	0	0	6	0	0	0	43	11	12	One part time M.D. teaches in Public Health, one in Engineering and one in Physiological Optics
Ferris State College of Optometry	100	31	.31	0	0	0	0	0	0	3	1	0	29	All but 2 of these 29 also teach in the Biolog and Chemistry departments of the Undergraduate College.

CAN MEDICAL EYE CARE BE ENTRUSTED TO OPTOMETRISTS WHEN THIS STUDY PROVES THAT THERE ARE NO FULL-TIME M.D. INSTRUCTORS IN ANY OPTOMETRY SCHOOL ANYWHERE?

Study Compiled for PEN Inc. by the EDUCATION CATALOG STUDY COMMITTEE OF THE SOU CAROLINA OPHTHALMOLOGICAL SOCIETY DECEMBER, 1977.

1468 29.

Optometrists say they need drugs in order to make a "better diagnosis" before referral. The purpose of referral is to obtain a diagnosis, and drugs are not needed to detect the usual reasons for referral (poor uncorrectable vision, inflamed or painful eye, high eye pressure). Diagnosis is a medical function which involves recognizing a disease state and hopefully pinpointing its cause. This is a function optometrists have not been trained - and are not required - to perform. It makes little sense, then, to allow optometrists to use drugs to "open" the eye to look for what they are not trained to recognize -- especially in light of the risks of these drugs when administered by untrained persons.

A similar conclusion was reached by Ohio Governor James Rhodes, as expressed in his veto message of optometric drug use legislation in Ohio, which follows.

Optometric drug use legislation similar to A.B. 580 was proposed in 17 states during 1978. In 13 of these states optometric drug use bills were defeated by floor vote; in 2 other states, such bills were vetoed by the Governors.

In Nevada the State Medical Association, the Clark County Medical Society, the Las Vegas Society of Eye Physicians and Surgeons, and the National Federation of the Blind of Nevada all concur that the health and safety of the public would be endanged if the optometric practices act were changed to allow optometrists to administer drugs. Their statements follow.

DANGEROUS DRUGS WOULD BE ADMINISTERED TO THE PUBLIC BY NON-PHYSICIANS UNDER A.B. 580

ANESTHETICS - Drugs to ease eye discomfort during applied force testing for glaucoma. Side effects include cardiac and respiratory failure, convulsions, and corneal epithelial lesions. Reactions can be triggered by allergies, cardiac disease, and hypertension. Reversing reactions to certain ocular anesthetics requires immediate injection of barbituates -- but optometrists are not allowed to keep barbituates or give injections.

MYDRIATICS - Drugs which dilate the pupil to allow examination of the interior eye using an opthalmoscope. Side effects include precipitation of acute glaucoma, hypertension (a common cause of stroke and heart failure), headaches, rapid heartbeat, blurred vision, and reactivation of herpes simplex. The Herpes condition results in blindness within ten years in nine out of ten patients.

MIOTICS - Drugs which are used to constrict the pupil after mydriatic dilation, in order to speed the recovery of normal eye use. Side effects include vomiting, diarrhea, muscle weakness, respiratory difficulties, cardiac irregularities, pulmonary edema, and bronchiolar spasm. The latter two side effects can be fatal. Administration of one miotic, phosopholine iodide, within six weeks prior to general anesthesia can cause respiratory or cardiovascular collapse during anesthesia.

CYCLOPLEGICS - Drugs which cause paralysis of eye muscles and loss of ability to focus on objects within a 20 foot range. These drugs are used to aid in refraction, particularly with young patients. Side effects include rapid heartbeat, fever, irritability, delirium, and acute psychotic reaction in children.

THESE ARE HIGHLY TOXIC SUBSTANCES WHICH CAN INDUCE HARMFUL, EVEN FATAL, REACTIONS. THEY SHOULD CONTINUE TO BE USED ONLY UNDER MEDICAL - NOT OPTOMETRIC - SUPERVISION.

EXHIBIT I

PDR®

1977/8

Physicians' Desk Reference®

For Ophthalmology

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1474.

EXHIBIT 1

4. Pharmaceuticals in Ophthalmology

by: Paul Henkind, M.D., Ph.D. and Joseph B. Walsh, M.D.

The section of Pharmaceuticals in Ophthalmology has been revised and expanded from the fifth edition. Again, only nonproprietary, N.F. (National Formulary) or U.S.P. (United States Pharmacopeia) names—often referred to as generic, are used. Proprietary or trade names appear in the product section, with indices relating to the product information.

At the request of many readers we have included a section dealing with the ocular side effects of systemic medications. Here too, only nonproprietary names for medications are given but ample space is left for the reader to write in the brand names of the various drugs. Data on suture material and ophthalmic lenses again included.

There are now numerous sources which contain useful material in pharmacology in general and as it pertains to ophthalmology. We have included a list of many of the more useful volumes.

General References:

1. A.M.A. Drug Evaluations 2nd edit. *Am. Med. Assoc.*, 1973.
2. Duke-Elder, W. S. *System of Ophthalmology*. Vol. VII. London: Kimpton 1962, pp. 462-727.
3. Ellis, P. and Smith, D. *Handbook of Ocular Therapeutics and Pharmacology*. 4th ed. St. Louis: Mosby, 1973.
4. Ellis, P., ed. *Side Effects of Drugs in Ophthalmology*. International Ophthalmology Clinics. Boston: Little Brown, Vol. 11, No. 2, 1971.
5. Goodman, L. S. and Gilman, A. *The Pharmacological Basis of Therapeutics*. 5th ed. New York: Macmillan, 1975.
6. Grant, M., *Toxicology of the Eye*, 2nd ed., Springfield, Ill., Thomas 1974.
7. Havener, W. H. *Ocular Pharmacology* 3rd ed. St. Louis: Mosby 1974.
8. Leopold, I. ed. *Symposium on Ocular Therapy:* Vol. 3 through 8. St. Louis: Mosby, 1968-1975.
9. *Symposium on Ocular Pharmacology and Therapeutics:* Transactions of the New Orleans Academy of Ophthalmology. St. Louis: Mosby, 1970.

EXHIBIT 1

I. Mydriatics and Cycloplegics

The topically applied autonomic drugs which produce mydriasis (pupillary dilatation) and cycloplegia (paralysis of accommodation) are among the most useful pharmacologic agents in ophthalmic practice. The common mydriatics comprise two groups of drugs: (A) Sympathomimetics; and (B) Parasympatholytics.

Sympathomimetic agents imitate (direct acting) or potentiate (indirect acting) the action of adrenaline, and their effect is upon the dilator muscle of the iris. They do not, with the exception of cocaine, cause cycloplegia. Table 1 lists their names and duration of action.

Parasympatholytic drugs produce pupil dilatation and paralysis of accommodation by rendering the pupillary sphincter and ciliary muscles insensitive to acetylcholine. Table 2 lists their names and duration of action.

It is important to remember that the effect of the autonomic drugs listed below depends upon many factors such as the age of the patient, the color of his iris and his race. For example, the mydriatics and cycloplegics tend to be less effective at the same dose levels in dark-eyed individuals as compared to blue-eyed ones.[2]

1. Davidson, S. I., Drug Interactions in Ophthalmology. *Trans. Ophth. Soc. U.K.* 95:277, 1975.
2. Lieberman, T. W. Individual responsiveness to Drugs and Pharmacogenetics in Ophthalmology. *In Symposium on ocular therapy;* Vol. 5, edited by I. Leopold St. Louis: Mosby 1972, pp. 100-103.
3. McKusick, V.: Symposium on inborn errors of metabolism: mechanism in genetic diseases of man. *Amer. J. Med.* 22:676, 1957.

Table 1—Sympathomimetic Drugs

U.S.P. or N.F. Name	Per Cent	Maximum Mydriasis	Duration of Mydriasis
Phenylephrine[a] †	10	≅20 minutes	≅3 hours
Adrenaline[a]*	1/1000		
Hydroxyamphetamine[b]	1	≅40 minutes	
Cocaine[b]	2-4	≅20 minutes	≅2 hours
Ephedrine[b]	5	≅30 minutes	≅3 hours

[a]Direct acting sympathomimetic; [b]Indirect acting sympathomimetic; * Poor mydriatic, but will dilate pupil of patient with Horner's Syndrome †Use with caution in patients taking monoamine oxidase inhibitors.[1]

Table 2—Parasympatholytic Drugs

U.S.P. or N.F. Name	Per Cent	Max. Mydriasis Max. Cycloplegia	Duration Mydriasis Duration Cycloplegia
Atropine*	0.25-4	≅30-40 minutes ≅several hours	≅12 days ≅2 weeks
Homatropine	1-5	≅10-30 minutes ≅30-90 minutes	≅6 hours—4 days ≅10-48 hours
Scopolamine	0.25-0.5	≅15-30 minutes ≅30-45 minutes	≅several days ≅5-7 days
Cyclopentolate	0.5-2	≅15-30 minutes 15-45 minutes	≅24 hours ≅24 hours
Tropicamide	1-2	≅20-30 minutes ≅20-25 minutes	≅4 hours ≅6 hours
Oxyphenonium**	1&5	Comparable to atropine	≅4 days ≅12 days
Eucatropine	5&10	≅30 minutes poor cycloplegia	≅4 hours

*Possible exaggerated pupil response or systemic reaction in Down's Syndrome[3]

**A useful substitute for atropine in sensitive individuals. (The figures for duration are only approximate and refer to maximal duration of effect.)

EXHIBIT 1

II. Miotics

Topically applied miotics are used in the treatment of glaucoma and in the management of accommodative estropia. These parasympathominetic drugs are either cholinergic (i.e., simulate the effect of acetylcholine at autonomic synapses or the neuroeffector junctions of the parasympathetic system), or anticholinesterases (prevent the hydrolysis of acetylcholine by the enzyme cholinesterase). The tables list the various topically-applied miotics. In addition, acetylcholine is available for intracameral injection (Miochol).

Reference:

1. Apt, L. Toxicity of strong miotics in children. *In Symposium on ocular therapy*, Vol. 5, ed. by I. Leopold. St. Louis: Mosby, 1972, p. 33.

Table 3

Cholinergic Drugs

U.S.P. or N.F. Name	Concentration	Duration of Miotic Action
Pilocarpine	0.25—10%†	4-8 hours
Carbachol	0.75—3%	2 hours
Methacholine (see section on diagnostic drugs)		
Bethanechol	1.0%	

†Also available as continuous release product (pilo-20; pilo-40, Alza)

Table 4

Anticholinesterases

U.S.P. or N.F. Name	Concentration	Duration of Miotic Action
Physostigmine (Eserine)[a]	0.25—1.0%	12-36 hours
Neostigmine[a]	3.0—5.0%	
Diisopropyl fluorophosphate[b]	0.01—0.1%	days to weeks
Echothiophate iodide[b, c]	0.03—0.25%	days to weeks
Demecarium bromide[b]	0.125—0.25%	days to weeks

[a] Reversible antioholinesterases

[b] Irreversible anticholinesterases, Pralidoxime Chloride and Atropine may counteract the effects of these agents

[c] Unusual hyperreactivity in Down's Syndrome (1)

III. Anti-Mi...

EXHIBIT 1

V. Anesthetic Agents

A. Topical anesthetics

Topical anesthetics (Table 15) permit the clinician to perform ocular procedures such as tonometry, removal of foreign bodies from the surface of the eye, and lacrimal canalicular manipulation and irrigation.

Cocaine, the prototype topical anesthetic, is a natural compound; the other agents are synthetics.

Table 15

Topical Anesthetic Agents

U.S.P. or N.F. Name	Concentration
Cocaine	0.25-0.5%
Benoxinate	0.4%
Dibucaine Hydrochloride	0.1%
Dyclonine Hydrochloride	0.5% (effective in 2-4 minutes)
Naepaine	4.0%
Phenacaine Hydrochloride	1.0%
Piperocaine	2.0% (solution) 4.0% (ointment)
Proparacaine Hydrochloride	0.5%
Tetracaine Hydrochloride	0.5%

The difference in chemical structure of Proparacaine Hydrochloride from other local anesthetics may explain its lack of cross-sensitization with other topical anesthetic agents.

Cocaine is rarely used as an anesthetic agent because it causes damage to the corneal epithelium, it produces pupillary dilatation, and it may affect the intraocular pressure. It is a useful agent when it is desired to remove the corneal epithelium, as in the case of epithelial debridement for dendritic keratitis.

The table lists the various agents and the concentrations which are available. Most of the agents work within a minute and their duration of action is between 10 and 20 minutes. A transient, superficial punctate keratitis may develop rapidly after the instillation of the agent.

B. Regional anesthetics

The actions and usefulness of the most commonly utilized regional anesthetic agents in ophthalmic surgery are summarized in Table 18. Prilocaine, a relatively new agent (in ophthalmic surgery) has been included in the table.

References:

1. Everett, W. G., Vey, E. K. and Finlay, J. W. Duration of oculomotor akinesia of injectable anesthetics. Trans. *Am. Acad. Ophth.* 65: 308, 1961.

2. Leopold, I. H.: Advances in anesthesia in ophthalmic surgery. *Ophth. Surg.* 5:13, 1974.

Table 16

Regional Anesthetics

U.S.P. or N.F. Name	Concentration Used Maximum dose	Onset of Action	Duration of Action	Major advantages/ disadvantages
Procaine*	1-4%/500 mg	7-8 mins.	30-45 mins. 60 mins. (with epinephrine)	Short duration. Poor absorption from mucous membranes
Tetracaine*	0.25%	5-9 mins.	120-140 mins. (with epinephrine)	
Hexylcaine*	1-2%	5-10 mins.	60 mins.	
Bupivacaine**	0.25-0.75%	5-11 mins.	400-420 mins. (with epinephrine)	
Lidocaine**	1-2%/500 mg	4-6 mins.	40-60 mins. 120 mins. (with epinephrine)	Spreads readily without hyaluronidase
Mepivacaine**	1-2%/500 mg	3-5 mins.	120 mins.	Duration of action greater without epinephrine (Everett et al[1])
Prilocaine**	1-2%/600 mg	3-4 mins.	90-120 mins. (with epinephrine)	As effective as lidocaine

* Ester type compounds
** Amide type compounds

EXHIBIT I
TAB VII

Nevada State Board of Medical Examiners

March 28, 1979

To: Assemblymen Robinson, Bennett, Bremner, Chaney, Horn, Sena, FitzPatrick, Rusk, Tanner and Weise

Dear Sirs:

This is with reference to AB 580.

The Board of Medical Examiners has considered the matter of this proposed legislation which would permit the use of drugs by optomotrists for diagnostic purposes.

The Board is of the opinion that there is a significant danger in the use of drugs to diagnose neurological, muscular, or anatomic anomalies or deficiencies of the eye by persons who do not have the requisite medical training and background, and that it would be detrimental to the health and welfare of our citizens to permit optomotrists to perform such medical functions.

For these reasons the Board has taken the position that NRS Chapter 636 should not be ammended by AB 580 to permit such medical practices.

Sincerely,

Kenneth F. Maclean, M.D.
Secretary-Treasurer

KFM/plp

1281 Terminal Way, Suite 211 • (702) 329-2559
Mailing Address: Post Office Box 7238 • Reno, Nevada 89510

EXHIBIT I

NEVADA STATE MEDICAL ASSOCIATION

NEIL SWISSMAN, M.D., President
RICHARD C. INSKIP, M.D. President-elect
GORDON L. NITZ, M.D., Secretary-Treasurer
ROBERT L. BROWN, M.D., Immed. Past President
LESLIE A. MOREN, M.D., AMA Delegate
LEONARD H. RAIZIN, M.D., AMA Alternate Delegate
RICHARD G. PUGH, CAE, Executive Director

3660 Baker Lane • Reno, Nevada 89509 • (702) 825-6788

February 7, 1979

To: Nevada State Legislators

From: Neil Swissman, M.D., President

Subj: Proposed Changes in Optometric Law

The Nevada State Medical Association supports the position on diagnostic drugs as outlined in a position statement issued by the Nevada Ophthalmological Society. We oppose the use of legend drugs for the diagnosis and treatment of medical conditions by untrained personnel as not being in the best interests of the citizens of our state.

Nevada is fortunate to have many excellent optometrists and ophthalmologists working together to provide the finest quality eye care for our residents and visitors. Both professions work within the framework of their respective practices act, and at the present time, only ophthalmologists by virtue of their extensive medical education and training are authorized to use drugs in diagnosis, therapy and treatment of drug-related complications.

We believe there would be significant danger to the public if the optometric practices act were modified to allow optometrists to expand the scope of their practice when it is apparent that schools of optometry are not, and have not been, providing adequate training for such expanded usage of drugs.

Our Association urges you to reject any petition by the optometric profession to expand the optometric practices act as outlined above and to oppose such legislation should it be introduced. Please call on me if I can be of assistance or provide additional information.

NS:d

EXHIBIT I

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Home: (702) 747-4811

March 26, 1979

Van B. Davis, O. D.
Vice President
Nevada Optometric Association
819 South Decatur Blvd.
Las Vegas, Nev. 89107

Dear Dr. Davis:

The Executive Committee of the Nevada State Pharmaceutical Association has reconsidered its position in regard to optometrists administering diagnostic drugs as stated in our letter of January 5, 1979.

The Executive Committee feels that inasmuch as optometrists are not requesting dispensing priviliges, which would be of concern to the pharmacy profession, that at this time, the controversy over the administering of diagnostic drugs is one which primarily exists between physicians (opthonologists) and the optometrists.

Generally, it is the position of the Nevada State Pharmaceutical Association that professional prerogatives be acquired through the high degree of professional training required to perform those professional prerogatives, rather than acquired through legislative mandate.

Very truly yours,

Mary Beth Arnold R. Ph.

Mary Beth Arnold, R. Ph.
President
Nevada State Pharmaceutical
Association

cc:
William Van Patten
O.D.
1200 N. Mountain
Carson City, N.V.
89701

To Executive Committee
John Bryan, M. D.
975 Ryland
Reno, Nevada 89520

1482

31.

EXHIBIT I

Southern Nevada Central Labor Council

Affiliated with the AFL-CIO and the Nevada State AFL-CIO
4321 EAST BONANZA ROAD LAS VEGAS, NEVADA
702—452-8899 — 452-8799

COMMITTEE ON POLITICAL EDUCATION

March 13, 1979

MEMORANDUM

The Southern Nevada Central Labor Council opposes the Act to Amend NRS 454.316, recently introduced to the 1979 Legislature.

Our opposition is based on universally recognized principles:

that optometry is not a medical profession and optomotrists must not be engaged in medical practice,

that optometry being a para-medical profession should be exclusively concerned with determining the refraction of the eye by methods that can be applied without the use of drugs;

that optometry must be kept confined to a limited area of the measurement for and fitting of eyeglasses and excluded from treating diseases of the eye or the practice of medicine and surgery.

This bill, by extending the practice of optometry to cycloplegic mydiatics, miotics and ophthalmic anesthetics, obviously exceeds the limit of determining refraction and invades the area of pathology of the eye for which the optometrist lacks training and qualification an from which they should remain excluded.

James M. Arnold,
Secretary-Treasurer

JMA:blg

National Federation of the Blind of Nevada

1001 North Bruce • Telephone 642-6000
Las Vegas, Nevada 89101

EXHIBIT J

February 15, 1979

As the president of the National Federation of the Blind of Nevada, I wish to go on record as being unequivocally opposed to the Assembly measure which will permit optometrists to administer eye drugs as a part of their practice.

We firmly believe such an intrusion by the optometrists into the medical profession may divert the optometrist from the full application of his highly developed skills and lead him into areas in which he is not qualified.

Even more, the administering of eye drops by an optometrist may lead some of his patients to the disasterous conclusion that they are receiving eye treatment regardless of any statement made by the optometrist.

Audrey Tait

Audrey Tait, President
National Federation of the Blind of Nevada

MEREDITH W. MORGAN, O.D.
. . . Optometric Educator

Optometric Educator: "A Lens Is Not A Pill"

While the optometrists of North Carolina and their non-medical lawmakers were deciding to deliver health care into the hands of the untrained, a distinguished optometric educator, Meredith W. Morgan, dean emeritus of the School of Optometry of the University of California at Berkeley, was proclaiming at an honors convocation in Alabama that ". . . This expansion (into medicine) is outside the traditional and historical scope of optometry."

The learned dean went on the say that, "As far as I know, there is not a school with a curriculum adequately designed to educate students in pharmaceutical therapy and there is not a school with adequate resources to establish such a curriculum."

Morgan, who told the new O.D.'s that he's seen the advent of all but two of the nation's 13 optometry schools, suggested that new graduates should be more concerned with performance than politics.

"I learned in my mechanical optics course to really adjust spectacles . . . When I went to school, optics — geometrical, ophthalmic and physiological — were the heart of optometry; today this is no longer true.

"I tend to deplore this change; superior knowledge of optics set optometry apart as an independent profession," he said, adding that optometry's original saying was 'A lens is not a pill.'"

Morgan called the movement to expand the scope of optometry into the use of pharmaceutical agents a "direct overreaction to negative criticism (of the profession) combined with a non-critical optimism growing out of successful legislative ventures.

"Such (legislative) solutions, unfortunately may be short term, as witness the demise of advertising restrictions. On the other hand, educational solutions tend to be more lasting . . .

"I firmly believe that the highest level of attainment in any profession is the use of intelligence and understanding rather than the use of any particular agent," Morgan said.

TAB VIII
EXHIBIT I

1486

34.

EXHIBIT

Optometric Expert Disavows Drugs

Henry B. Peters, Dean and Professor of Optometry and Epidemiology at the University of Alabama takes a strong position against optometry's attempt to invade the practice of medicine as shown in these excerpts from an editorial in the American Journal of Optometry and Physical Optics, Vol. 53 May 1976.

"We have repeatedly stated that the treatment of eye disease was the practice of medicine- ophthalmology.

"I must object to altering the basic posture of the profession...

"...Optometry has grown and prospered, without invading medicine, by the development of excellence in non-medical treatment of vision problems. As a part-time epidemiologist I offer that medical treatment of eye disease is an inappropriate goal for optometry. ...

Uptometry can secure a larger proportion of patients with non-medical eye problems by concentrating on perfecting their non-medical treatment services. Excellence in the quality of service and cost effectiveness in its delivery will be the key to this development of the profession, not the invasion of medicine.

EXHIBIT

Richard J. Ball O.D., PH.D. Opposes Optometric Drug Use

"Our profession exists because we satisfy patient care needs by practicing as first class optometrists and not as second class ophthalmologists."

"However in West Virginia optometry is attempting to significantly expand its scope of practice into an area where I feel very strongly that we are not properly prepared and will not be prepared in the foreseeable future with our current educational programs. An equally important philosophical question is whether optometry should significantly modify its educational programs to encompass an area that is already covered by the acknowledged expertise of ophthalmology. I feel the answer to this question is an emphatic NO!

"Some state that this problem of therapeutics is based on economics. However, I feel that this is erroreous and that most of the problem is based on professional ego and pride. If you really believe that utilization of therapeutic drugs is an economic issue, your whole argument is ridiculous for you are talking about something that is significantly less than ten percent of all the eye and vision problems."

"Our future, economically, professional-pride-wise, and most importantly, patient-care-wise, lies in the direction of rendering first class optometric care, not second class ophthalmological care. A few of our colleagues are unfortunately misguided and are pointing our profession in the wrong direction-- please do not let them jeopardize the great future of optometry."

Excerpted from Optometric Weekly
August 12, 1976

EXHIBIT —

"Our profession exists because we satisfy patient care needs as first class optometrists and not as second class ophthalmologists"

Richard J. Ball
Optometric Weekly
August 8, 1976

"Optometry has long held, demonstrated, and tried to prove the use of drugs for diagnostic purposes relative to conditions of the visual system are not only needless, but more important, are limiting."

Robert M. Greenburg, O.D.
Optometric Weekly
Sept. 1, 1977

" Is optometry really and truly thinking of the welfare of the patient or his own welfare when he wants to use drugs? I question the motive behind the need for drugs."

Albert L. Shankman, O.D.
Optometric Weekly Dec. 23, 1976

"Dallying with military, health, and drug bills when we are at the very brink of disaster and about to be flushed down the tube is about as insane as painting and improving your house as it burns down"...

David Surkin, O.D.
Optometric Weekly
Aug. 25, 1977

"Most of the major advances in our profession have come about as a result of our 'drugless status'." "I perform a valuable service in my community and hope to continue to do so. I've come to this point without using drugs." I wish-- that my profession would continue to grow in the same fashion."

Arnold Katz, O.D.
Journal of the American
Optometric Association
Nov. 15, 1976

Iowa Survey Reveals 67% Of Public Oppose O.D. Drug Bill

An impartial statewide survey recently conducted in the state of Iowa revealed that 67% of the adult population did not want the Iowa law changed to permit optometrists to use drugs in their patient's eyes.

This study, conducted in December 1977, through the Iowa Market/Opinion Survey (IMOS) utilized personal in-home interviews conducted by professional interviewers and was made in conjunction with "The Iowa Poll." "The Iowa Poll" is a project of Iowa Market Research Services, Commercial Research Division, Des Moines Register & Tribune Co., Des Moines, Iowa.

Respondents in this survey were read the question, then handed a card with the responses written on it. The question and responses were as follows:

The State Legislature will be considering a Bill to allow optometrists, who are non-medical practitioners, to use certain drugs in their patients' eyes for diagnostic purposes. Currently, in Iowa, only medical doctors can legally use drugs in their patients' eyes. Which of the following would you favor? (Card.)

1. Change Iowa law to allow optometrists (non-medical practitioners) to use drugs in their patients' eyes for diagnostic purposes.

2. Leave Iowa law as it is which permits only medical doctors to use drugs in patients' eyes.

The sample consisted of 591 interviews, and according to IMOS is representative of Iowa adults, 18 years of age and older.

The survey covered 17 respondent classification questions on age, occupation, income, education, etc. to determine the validity of the state-wide sample.

The survey showed greatest opposition to changing the law coming from adults living in metropolitan areas where 71% were opposed.

Of particular significance, however, was the fact that 60% of the farmers in this largely rural state were opposed to change and 11% had no opinion. Iowa has only one city with a population in excess of 200,000 and six cities with approximately 100,000 residents.

Women in the survey strongly opposed changing the law with 71% against. While all income groups recorded majority opposition to changing the law, opposition was notably high among low income families. Families with incomes of $10,000 or less responded 71% against allowing drug use by optometrists and respondents with college education were opposed by 69%, with 3% showing no opinion.

The IMOS survey concluded that "In no instance did any group indicate majority support for changing the existing law. Generally, the people of Iowa, regardless of age, sex, education, etc. would not like to see the Iowa Legislature change the existing law regulating the use of drugs by optometrists."

Eye Care Quality Erodes In West Virginia

As the issue of whether non-medical optometrists should be allowed the use of dangerous eye drugs comes up before legislatures throughout the country, medical doctors are reporting specific cases of damage and misdiagnosis in West Virginia.

'eye strain.' After refraction he looked at her eyes with a slit lamp and told her that her left eye had a malignant melanoma of the iris. He called another person (an optometry student) to see it and told him that about 13% of his patients had these

Neurosurgeon Calls For Drug Bill Defeat

Medical doctors from specialties other than ophthalmology are beginning to express concern directly to their legislators as optometrists attempt to gain drug-use by legislative fiat.

Charles R. Loar, M.D., a neurosurgeon from Martinsville, Virginia, is one such M.D. He wrote the following letter to Virginia Delegate John D. Gray, showing, with case histories, optometrists' lack of medical education.

"It is my understanding that there is a bill before your committee, at the present time, which would expand the responsibilities and powers of optometrists in the state of Virginia. Because of my past experience as a neurosurgeon dealing with patients referred by optometrists, I find this very alarming. It has been my experience that most, if not all, optometrists are extremely unskilled in physical diagnosis and tend to either under-rate the seriousness of patients' complaints, or pay little attention to rather obvious, serious physical findings.

"Several recent cases come to mind rather readily. One involves a gentleman, who had complained of progressive loss of vision for a period of about two years. During that time he was followed at regular intervals by his optometrist who prescribed frequent changes in his eyeglasses. He failed to notice the rather obvious physicial findings which suggested the true diagnosis, a tumor pressing on his optic nerves. This patient was not referred for medical evaluation until he was legally blind. This was certainly tragic because this patient's severe loss of vision could have been avoided by early diagnosis and proper treatment. I certainly feel that any physician would have recognized the patient's problem and referred him for proper treatment.

"Two other cases I have seen recently also demonstrate the poor diagnostic abilities of optometrists. One was a young lady who had double

1480 28

Exhibit

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

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"SUDDEN DEATH" FOR O.D. DRUG BILLS

MISSISSIPPI PATIENTS PROTECTED FOR 5th CONSECUTIVE YEAR

An early attempt by optometrists to invade medicine at the expense of the public health in Mississippi died in the Subcommittee of the House Pensions, Social Welfare and Public Health Committees on Thursday, February 2. Medicine in Mississippi salutes Committee members for their caution in not acting on the measures while they had the opportunity. Overambitious optometrists were unable to muster enough votes to pass out either H.B. 224 or 102 favorably before the midnight deadline.

Thus the optometric drug use enabling proposals are dead for this session, according to Robert O. May, M.D., of Jackson, Miss., a director of PEN, Inc. who had led the vocal and visible public campaign to defeat the proposal in the Magnolia State. A complete text of Dr. May's eloquent testimony will appear in a future issue of THE PEN.

VA. DELEGATES CAUTIOUS

The defeat of the Mississippi bills came swiftly after the demise of similar legislation in Georgia. On the same Thursday, a Virginia House of Delegates Health, Welfare and Institutions Committee displayed what PEN Advisory Board member Harry Taylor, M.D., of Norfolk has termed "commendable caution" by failing to pass out H.B. 205, an O.D. drug use proposal. The committee, after hearing Dr. Taylor, and former O.D. Roger Hiatt, M.D. (see page 1, Col. 3) of the University of Tennessee referred the issue to a study committee of five. The proposal is to be analyzed by Chairman Rep. Owen B. Pickett of Virginia Beach; Thomas J. Michie, Jr., Charlottesville; Norman Sisisky, Petersburg; Mrs. Mary Marshall, Arlington, and J. Samuel Glasscock, Suffolk.

As the heated issue and public warnings attract banner headlines throughout Virgina, the concerns of patients about the erosion of health care inherent in the optometric proposals are being expressed to the subcommittee.

"It's obvious that our lawmakers will not be stampeded, and all of medicine in Virginia applauds their caution" was the comment of William Hagood, M.D., Clover, Va., president of the Medical Society of Virginia.

"The action of legislators in Georgia, Mississippi and Virginia seem to indicate that informed government will reject the invasion of medicine at the expense of the public health," was the comment of Alton Ochsner, M.D., chairman of the International Advisory Board of PEN, Inc.

ROGER L. HIATT, M.D.
. . . testifies at Va. Hearing

Roger L. Hiatt, M.D., is an eminent professor, physician, and former optometrist. He is a graduate of the Southern College of Optometry with an O.D. degree and received his M.D. degree from the University of Tennessee School of Medicine in 1958. He served a rotating internship and a residency in ophthalmology at the Medical College of Virginia and a fellowship in pediatric ophthalmology at the Childrens Hospital in the District of Columbia. He is a Diplomate of the American Board of Ophthalmology, a member of the American Ophthalmological Society, and a member of the American Academy of Ophthalmology and Otolaryngology. He currently serves as Professor and Chairman of the Department of Ophthalmology of the University

BULLETIN AT PRESSTIME:

Disabled Vets Demand Medical Eye Care By VA

In "Diagnoses" THE PEN editorial (page 2),

Neurosurgeon Calls For Drug Bill Defeat

Medical doctors from specialties other than ophthalmology are beginning to express concern directly to their legislators as optometrists attempt to gain drug-use by legislative fiat.

Charles R. Loar, M.D., a neurosurgeon from Martinsville, Virginia, is one such M.D. He wrote the following letter to Virginia Delegate John D. Gray, showing, with case histories, optometrists' lack of medical education.

"It is my understanding that there is a bill before your committee, at the present time, which would expand the responsibilities and powers of optometrists in the state of Virginia. Because of my past experience as a neurosurgeon dealing with patients referred by optometrists, I find this very alarming. It has been my experience that most, if not all, optometrists are extremely unskilled in physical diagnosis and tend to either under-rate the seriousness of patients' complaints, or pay little attention to rather obvious, serious physical findings.

"Several recent cases come to mind rather readily. One involves a gentleman, who had complained of progressive loss of vision for a period of about two years. During that time he was followed at regular intervals by his optometrist who prescribed frequent changes in his eyeglasses. He failed to notice the rather obvious physicial findings which suggested the true diagnosis, a tumor pressing on his optic nerves. This patient was not referred for medical evaluation until he was legally blind. This was certainly tragic because this patient's severe loss of vision could have been avoided by early diagnosis and proper treatment. I certainly feel that any physician would have recognized the patient's problem and referred him for proper treatment.

"Two other cases I have seen recently also demonstrate the poor diagnostic abilities of optometrists. One was a young lady who had double vision caused by paralysis of one of her muscles controlling eye movements, plus swelling of the optic nerves. This patient was referred immediately by the optometrist, but he failed to recognize a rather obvious physical finding. In another incident, I discovered that one of my patients had been treated by an optometrist for a congenital weakness of an eye muscle. The girl was much too old to respond to the kind of treatment that he had prescribed, and it was only after a rather thorough neurological evaluation that we were able to rule out the possibility of a dangerous medical condition accounting for her problems. In that case the optometrist completely failed to recognize the seriousness of the patient's symptoms and findings and failed to refer her for proper treatment.

"These are not isolated cases. This lack of expertise has been a rather consistent finding in my dealing with optometrists. In fitting eyeglasses they certainly perform a valuable service in the community. However, the expansion of their responsibilities would negate that value and would in fact make them in my opinion a hazard to the community.

"Thank you for your consideration of this matter."

1492
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EXHIBIT

TAB IX
EXHIBIT I

MEDICAL MALPRACTICE STANDARD OF CARE

I. Based on what a reasonably competent member of the profession practicing in the same specialty as the defendant would be expected to do in order to conform to the approved conduct of professional practice. Blair v. Eblen, 461 S.W.2d 370 (1970).

* * *

Ophthalmology case. Helling v. Carey, 519 P.2d 981 (1974), establishes the requirement for routine glacoma testing.

II. Practitioners from related professions are held to the same standard of duty and performance when stepping into another specialist's field. Simpson v. Davis, 549 P.2d 950 (1976).

III. Must use expert testimony (ophthalmologists) in most cases to establish breach of duty to patient. Opth almologists will be testifying against optometrists.

IV. See also Loyola Law Review, Vol. 24, pp. 221-238 (1978), entitled "Optometric Drug Laws, Their Propriety and Malpractice Ramifications."

EXHIBIT "L"

EXHIBIT

Optometric "Primary Care" Results In Loss of Eye For Four-Year-Old Boy

1495

In a landmark decision that could cause the army to re-examine its policy permitting optometrists to provide initial eye care treatment, Judge James M. Fitzgerald, United States District Judge for the District of Alaska, ruled that Timothy Steele, now an eight-year-old dependent of a soldier in the U. S. Army, was entitled to recover for the loss of his right eye.

> **"I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye."** *JAMES M. FITZGERALD, U.S. District Court*

Judge Fitzgerald's decision was rendered on October 20, 1978, in the case of Timothy R. Steele and Robert K. Steele, plaintiffs, vs. The United States of America, defendant. In his opinion, Judge Fitzgerald stated, "An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases, he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to seek a qualified medical doctor."

The litigation stemmed from a claim brought on Timothy Steele's behalf by his father against the United States for the loss of Timothy's right eye. Timothy Steele, as a four-year-old boy, was treated by John Shank, O.D., an optometrist in charge of the Eye Clinic at Bassett Army Hospital, Fort Wainwright, Alaska.

According to testimony in the case, it was in October and November of 1973 that Timothy's mother first noticed that his eyes were crossing. On December 19, 1973, she took him to Bassett Eye Clinic where he was seen by Dr. Shank.

During his examination, Dr. Shank measured Timothy's vision and found it to be normal. He then used drops to dilate the pupil and looked inside the eye. He diagnosed Timothy's eye condition as accommodative esotropia, which is correctable by eyeglasses. He wrote a prescription for eyeglasses and made an appointment for Timothy to return to the clinic on January 29, 1974, for a checkup.

On January 29, 1974, Timothy reported to Dr. Shank as requested. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steele to make another appointment for Timothy four months after he would begin wearing the new glasses.

The testimony further reveals that in early May, Mrs. Steele noticed that Timothy frequently removed his glasses, saying sometimes he could not see well with them.

On June 10, 1974, Timothy was again examined by Dr. Shank and it was then that he discovered that the vision in Timothy's right eye was limited to light perception. At this point, Dr. Shank made

to Letterman Army Medical Center where he was examined on July 12, 1974.

At Letterman, it was determined that, because the danger of retinoblastoma, a fast-spreading, life-threatening malignancy, Timothy's eye should be removed. With parental consent, the surgery was performed by Major Bradley C. Black, M.D.

When the pathological report ruled out retinoblastoma, Timothy was returned to surgery and an implant was placed in the socket. Although recovery appeared to be good, Timothy continued to suffer from periodic socket inflammation.

In September of 1974, Timothy returned to Letterman Medical Center where a prosthesis was inserted in the socket. Testimony revealed that since the prosthesis could not be inserted immediately following the operation, it is unlikely that it will ever appear similar to a natural eye. ●

A SAD SUMMARY:

- **When Timothy was four, his mother noticed his eyes crossing.**
- **A military dependent, he was taken to an army hospital where he was seen by an optometrist, instead of an M.D. (Current standard U.S. military procedure).**
- **The optometrist disregarded disease, infection or malignancy as causes and prescribed eyeglasses. Despite three visits, two pairs of eyeglasses and advancing blindness, Timothy was not referred to an M.D. ophthalmologist for six months, until after his right eye was blind.**
- **Ophthalmologists immediately recognized the probability of either retinoblastoma (malignancy) or toxocara canis (a parasitic worm infection), either of which is treatable in the early stages.**
- **The doctors recommended to [illegible]othy's par-**

AN OPEN LETTER SEEKS REPEAL

EXHIBIT

1496

43.

W. Va. Eye Victim Deplores Optometric Care

A West Virginia supermarket cashier, who is blind in her left eye and who has a serious problem with her right eye, has made a public appeal through an open letter for repeal of West Virginia's optometric drug law.

In a signed deposition, Mrs. Laura Dent of South Charleston, WV, states, "If my optometrist had been qualified to diagnose and treat diseases of the eye, maybe this disease would have been caught in time and I could read with my left eye. The people who passed this law (West Virginia law permits optometrists to use drugs for diagnosis and treatment), should stop and think what they have done; apparently some of them have never had serious eye problems or they would have known better than to do such a thing."

Saying, "I am firmly against this law allowing optometrists to prescribe medications and treat diseases of the eye, because they are not qualified," Mrs. Dent emphasized she was not offering an opinion, but was speaking from experience. Mrs. Dent related that in May of 1975 she went to see an optometrist for a general eye examination. At that time, she points out, the optometrist prescribed new glasses and advised that there were no signs of glaucoma or any other diseases of the eye. Within two weeks, Mrs. Dent said, "I was seeing distorted. I phoned my optometrist and asked what could be the problem. I was told to come in and be checked. I went in and was told it was only astigmatism, to wear my glasses all the time, and the problem would be corrected.

"It did not improve, I continued to get worse. I phoned my optometrist back in three weeks and asked just how long it would take to improve, and also asked if my family doctor could help. I was told maybe so. I will phone him; go ahead and see him.

"I went straight to my family doctor; the optometrist did not phone him. My family doctor took one look at my eye and panicked. He said there was this tremendous deterioration in both eyes, he did not know what it was, but there definitely was a problem. He sent me straight to Dr. Rashid's office. Doctors Rashid and Toma (both ophthalmologists) checked my eyes and told me I had histoplasmosis (a disease caused by a parasitic fungus) and said it was presently active in my

left eye. Since I had had numerous attacks in both eyes in the past, it was likely I had the disease all my life."

Mrs. Dent further relates that after six months of treatment, the condition did not improve and in September the laser was used to arrest the disease. She says, "It stopped the disease, but it did not save my vision. *Medical editor's footnote: Histoplasmosis is a chronic disease characterized by irregular active and inactive phases. Even during the inactive phases the lesions are easily seen. In the inactive phases, treatment is neither effective nor necessary. In the active phases, treatment is available and frequently helpful to retard or eliminate visual loss. Thus, the patient should be observed by a physician with an understanding of the disease process in order to minimize loss of visual function.* I have no central vision in my left eye; I have peripheral [redacted] but I cannot read; I cannot watch TV or do any close work at all with my left eye." In June of 1978 Mrs. Dent suffered a repeat attack in her right eye. This time the laser was used and Mrs. Dent advises she "is in pretty good shape except for the fact that I have a small blind spot."

Noting that the diagnosis made by Doctors Rashid and Toma was confirmed by Dr. Finklestein at the Wilmer Eye Institute in Baltimore, Mrs. Dent says, "I have been told that there is no hope for my left eye and it could happen again at any time in the right eye."

Calling on the legislature to take action now, Mrs. Dent writes, "I wish you would reconsider and repeal this law because a lot of innocent people are going to suffer unknowingly and maybe even go blind because they are t[redacted] an unqualified optometrist."

TREATMENT DELAYED

EXHIBIT

Mrs. Clara Jones

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Writes Iowa Legislature

Vol. 2, No. 2, Jan. 15, 1978

The following excerpts are from a story headlined "Damaged Patient Writes Lawmakers," which carried a letter that an Iowa woman wrote to the entire Iowa Legislature, reminding them that optometrists have no medical training:

"For the last 25 years my family has been going to an optometrist for our eye care needs.

"Some time after the most recent change of lenses, I began experiencing difficulty with my vision. Consequently I returned to my optometrist and told him my sight in my right eye was blurred and that something was wrong. After his examination he told me my glasses were correct, the blood vessels were healthy, and further there were no signs of glaucoma or cataracts.

"I still believed that something was wrong in my right eye but believed the doctor must know, so accepted his diagnosis. However, as the difficulty continued and gradually increased, after five months I decided to consult a medical eye specialist. In his preliminary examination he immediately suspected glaucoma which was subsequently verified in both eyes and that the disease had been there for a long time. Also the cataracts are starting. I am informed that a considerable portion of my vision has been lost due to the delay of treatment and cannot be restored, all due to a false sense of security given me by my optometrist.

"My medical doctor tells me that an optometrist is not trained in medicine nor to diagnose eye diseases.

"Because of this lack of training, the optometrist, in my opinion, should be severely penalized when he tries to perform such services which could well end in blindness for his patient.

"I strongly urge you to give this matter your most rigid study and action."

Mrs. Jones later told her ophthalmologist that vision loss was not the only way she suffered due to the optometrist's bold attempts to practice medicine.

"I fell twice," she said, "broke my right arm near the shoulder and the second time my left wrist. I still can't see a step."

Her physician, Leo J. Plummer, M.D., reports that her glaucoma is currently under control, on a program of medications. The Des Moines ophthalmologist notes that dense and extensive visual defects in both eyes are permanent, and that it is necessary for her to learn to walk with her head down to avoid tripping. Dr. Plummer has noted that the drugs Iowa optometrists seek to use are not necessary for the trained physician to suspect, or in most cases, diagnose glaucoma. ●

N.C. Patient Victim Of Therapeutic Drug Law

There is increasing evidence that North Carolina's new law allowing non-medical optometrists the use of therapeutic drugs is resulting in eye damage and danger to eye care patients in the Tarheel State. One such documented case has been provided to THE PEN by William W. Foster, M.D. of Raleigh, N.C., who has asked PEN editors to publish the following statement:

"I know many fine optometrists, all of whom perform a very useful service in fitting glasses and contact lenses. However, optometrists are not medical doctors and they should leave medical and surgical diagnosis and treatment of eye disease to ophthalmologists (medical doctors) who specialize in eye disease."

"After seeing my optometrist more than a dozen times in the last months at $15 per visit, and buying glasses I couldn't use, I am still suffering with aching, burning eyes." With these words, Cheryl Dawson related her remarkable experience to William Wade Foster, M.D., practicing ophthalmologist of Raleigh, N.C., on Feb. 24, 1978.

"For more than a month," the 31-year-old patient told Dr. Foster, "I have been going to an optometrist about every other day for treatment of what he calls 'Herpes' *(an acute inflammation of the corneal tissue caused by a virus)*. My eyes still ache and burn, although I have used the medicine he prescribed religiously. I just think I need another opinion."

Dr. Foster's examination of Ms. Dawson revealed that her eyes were healthy except for inflammation of both corneas manifested by multiple fine spots of damaged tissue caused by the medication. There was no indication either from her history or her examination that herpes had ever been present in her eyes.

He told the patient to stop all medication and use artificial tears (Tears Naturale) to remove the effects of the medication.

"To determine whether or not Cheryl's internist had been consulted regarding the medication prescribed by her optometrist," Dr. Foster said, "I called William Bellamy, M.D. He advised that the optometrist had called him reporting that the patient had conjunctivitis, but he did not 'collaborate' or approve the prescription written by the optometrist as required by North Carolina law."

On Feb. 28, 1978, Cheryl Dawson returned to see Dr. Foster, complaining that her eyes still burned and ached. "I again examined the patient," Dr. Foster said, "and found that although her eyes had improved, there was still some inflammation. To verify my diagnosis, I had Dr. Hicks, with whom I am associated, also examine the patient. He confirmed my findings."

"On March 9, 1978," Dr. Foster said, "Cheryl called to report she still had some symptoms — especially burning — and asked to be seen at the Duke University Medical Center. Both Dr. Hicks and myself felt another medical opinion was indicated, aand I made the necessary arrangements."

M. Bruce Shields, M.D., and John Reed, M.D., both members of the Department of Ophthalmology at the Duke University Eye Center, examined Ms. Dawson on March 15, 1978. Their findings confirmed Dr. Foster's original diagnosis and specifically indicated that 'Herpes' was never present. They recommended that all medication be discontinued.

Ms. Dawson returned to see Dr. Foster on April 7, 1978, this time to express her appreciation. "I am most grateful," she said, "for what you and other medical doctors have done for me. I hate to think of what might have happened had I continued to see my optometrist."

An examination of the patient on this visit showed that her vision was 20/20, uncorrected in each eye (despite the fact she had been sold glasses by her optometrist) and that all symptoms had disappeared.●

POWER PLAYS MULTIPLY

Mounting evidence points to the fact that present government policies are fostering, and political pressures are forcing, the lowering of today's high medical standards. The medical profession's achievements of the past 50 years are under attack and seriously threatened. This trend is evidenced by the retirement of Col. Budd Appleton (see story above) and events taking place at the University of Alabama Medical School (see "Diagnoses," page 2).

EXHIBIT

PUBLIC DANGER DOCUMENTED

ANNUAL REVIEW

As pu

TUMOR OVERLOOKED

Mrs. Lois McWalters

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Massachusetts Widow

Vol. 1, No. 1, July 15, 1977

The first issue of THE PEN featured a tragic testimonial headlined "Massachusetts Widow: 'It Seems Bizarre.'" Excerpts follow:

Five years ago my husband began complaining about his eyesight. He decided to see an optometrist and he continued to do so for 2½ months. As his vision deteriorated at this time, he experienced headaches so violent they would awaken him from a sound sleep. I pleaded with him to see an ophthalmologist or some person with a medical background. He became increasingly irritated at my suggestions and I was forced to bow to his decision or submit to an unhappy home life.

As each day passed, before my eyes his personality changed; this sweet gentle man became verbally abusive and the general tenor of our home was unbearable. At that time our four children were 6, 7, 8, and 9 years old. They watched their father hold a cup of coffee, his hand tremors so pronounced he would spill it and leave the table in a terrible rage.

I pleaded again, to no avail. How does a wife forcibly take a grown man to a doctor? He *trusted* the optometrist. The optometrist changed his glasses three times - each prescription being for stronger lenses - during those 2½ months. Each time his eyesight and the pain was not even slightly improved by the change of glasses. He was told it would take time to get used to them. The optometrist never suggested he see a medical person.

His suffering increased to such a point he could not work or concentrate. I suggested a vacation and

EXHIBIT ___

2. The following summary is taken from the report of F.T. Fraunfelder, M.D., and Arnauld F. Scafidi, M.D., which was issued in consequence of a study funded by the U.S. Food and Drug Administration, Contract #223-76-3018:

"Based on case reports submitted to the National Registry of Drug-Induced Ocular Side Effects, 27 cases of adverse side effects possibly related to ocular 10% phenylephrine application are summarized. These cases include 12 myocardial infarcts, 9 of which were terminal, 6 additional cases requiring cardiopulmonary resuscitation, and the remainder primarily marked elevation of blood pressure . . . Possible guidelines for the use of 10% phenylephrine hydrochloride are suggested."

(Emphasis added)

TAB X
EXHIBIT I

PANEL DOCTOR'S PROCEDURE MANUAL

EXHIBIT ____

CONFIDENTIAL FEE SCHEDULE
NEVADA

TYPE	FEE
EXAMINATION	
Vision Survey	$10.00
Vision Analysis	23.00
Tonometry	4.00
Biomicroscopy	3.00
PRESCRIBING FEE	2.00
LENS SERVICE FEES	
Single Vision	$12.00
Bifocal	19.00
Trifocal	24.00
Lenticular (Aphakic)	35.00
FRAME SERVICE FEE	$ 9.00
SPECIAL LENS SERVICE	$ 1.00
CONTACT LENSES	
Monocular	$120.00
Binocular	190.00
Lenticular (Monocular)	140.00
Lenticular (Binocular)	225.00

THE ABOVE AMOUNTS ARE IN ADDITION TO
WHOLESALE MATERIAL COST

CASE - When a new frame is allowed and supplied, VSP automatically adds $1.00 to the lab fee.

TAX - We automatically add the standard tax rate for the materials. If the tax rate for your area is different, this must be indicated on the Benefit Form.

1503

4. If the judgment of the district court [shall be] *is* against the officer complained of and an appeal is taken from the judgment so rendered, the officer so appealing shall not hold the office during the pendency of the appeal, but the office shall be filled as in case of a vacancy.

Senate Bill No. 439—Committee on Commerce and Labor

CHAPTER 472

AN ACT relating to medicinal substances; authorizing registered nurses to dispense controlled substances and dangerous drugs under certain circumstances; requiring records of refilled prescriptions to indicate the number of dosage units; mandating separate registration for each place of business of laboratories, manufacturers and wholesalers; and providing other matters properly relating thereto.

[Approved May 12, 1977]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 453.056 is hereby amended to read as follows:

453.056 A controlled substance or drug is "dispensed" if it is delivered to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, or is furnished to an ultimate user personally by a physician, physician's assistant if authorized by the board, dentist, [or] podiatrist *or registered nurse, when the nurse is engaged in the performance of any public health program approved by the board,* in any amount greater than that which is necessary for the present and immediate needs of the user. Dispensing includes the prescribing, administering, packaging, labeling or compounding necessary to prepare the substance for that delivery.

SEC. 2. NRS 454.221 is hereby amended to read as follows:

454.221 1. Any person who furnishes any dangerous drug except upon the prescription of a physician, dentist, podiatrist or veterinarian is guilty of a gross misdemeanor, unless the dangerous drug was obtained originally by a legal prescription.

2. The provisions of this section do not apply to the furnishing of any dangerous drug by: [a]

(a) A physician, physician's assistant if authorized by the board, dentist, podiatrist or veterinarian to his own patients as provided in NRS 454.301; [or by a]

(b) A registered nurse while participating in a public health program approved by the board; or

(c) A manufacturer or wholesaler or pharmacy to each other or to a physician, dentist, podiatrist or veterinarian or to a laboratory under sales and purchase records that correctly give the date, the names and addresses of the supplier and the buyer, the drug and its quantity.

SEC. 3. NRS 454.271 is hereby amended to read as follows:

454.271 A record of each refill of any prescription for a dangerous drug or any authorization to refill such a prescription shall be kept on the back of the original prescription, or on a separate card or paper securely attached thereto, showing the date of each refill or authorization *and the number of dosage units,* and shall be signed or initialed by the pharmacist who refilled the prescription or obtained the authorization to refill.

SEC. 4. NRS 454.281 is hereby amended to read as follows:

454.281 1. Every laboratory, manufacturer and wholesaler doing business in the State of Nevada shall be registered with the board.

2. Each laboratory shall keep purchase records.

3. Each manufacturer shall keep purchase and use records and sales records.

4. Each wholesaler shall keep purchase and sales records.

5. A separate registration is required at each place of business of each laboratory, manufacturer or wholesaler.

SEC. 5. Chapter 639 of NRS is hereby amended by adding thereto a new section which shall read as follows:

The board may adopt such regulations as may be necessary to assure that proper and adequate safeguards, including dispensing procedures, are followed to protect registered nurses who participate in public health programs approved by the board.

SEC. 6. NRS 639.019 is hereby repealed.

SEC. 7. Sections 1 and 2 of this act shall become effective at 12:01 a.m. on July 1, 1977.

Senate Bill No. 139—Committee on Commerce and Labor

CHAPTER 473

AN ACT relating to health care; regulating the practice of osteopathic medicine; renaming the state board of osteopathy as the Nevada state board of osteopathic medicine; increasing the number of members of the board; providing for licensing and disciplinary actions; providing penalties; amending various chapters and sections of NRS to delete redundant terms and clarify the meaning of certain other terms; and providing other matters properly relating thereto.

[Approved May 12, 1977]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. Chapter 633 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 75, inclusive, of this act.

SEC. 2. *As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3 to 15, inclusive, have the meanings ascribed to them in those sections.*

SEC. 3. *"Board" means the state board of osteopathic medicine.*

SEC. 4. (Deleted by amendment.)

SEC. 5. *"Employing osteopathic physician" means an osteopathic physician licensed in this state who employs and supervises an osteopathic physician's assistant with board approval.*

SEC. 6. *"Gross malpractice" means malpractice where the failure to exercise the requisite degree of care, diligence or skill consists of:*

1. Performing surgery upon or otherwise ministering to a patient

TAB XI

EXHIBIT 1

1505

So.

(b) Been convicted of a violation of any state or federal law relating to any controlled substance or of any felony, or had his registration or license to manufacture, distribute or dispense controlled substances revoked in any state;

(c) Had his federal registration suspended or revoked to manufacture, distribute or dispense controlled substances;

(d) Surrendered or failed to renew his federal registration;

(e) Ceased to be entitled under state law to manufacture, distribute or dispense a controlled substance; [or]

(f) Failed to maintain effective controls against diversion of controlled substances into other than legitimate medical, scientific or individual channels [.] *; or*

(g) Failed to keep complete and accurate records of controlled substances purchased, administered or dispensed.

2. The board may limit revocation or suspension of a registration to the particular controlled substance with respect to which grounds for revocation or suspension exist.

3. If the board suspends or revokes a registration, all controlled substances owned or possessed by the registrant at the time of suspension or the effective date of the revocation order may be placed under seal. No disposition may be made of substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application therefor, orders the sale of perishable substances and the deposit of the proceeds of the sale with the court. Upon a revocation order's becoming final all controlled substances may be forfeited to the state.

4. The board shall promptly notify the bureau and division of all orders suspending or revoking registration and the division shall promptly notify the bureau and the board of all forfeitures of controlled substances.

5. A registrant shall not employ as his agent or employee in any premises where controlled substances are sold, dispensed, stored or held for sale any person whose pharmacist's certificate has been suspended or revoked.

SEC. 4. NRS 453.251 is hereby amended to read as follows:

453.251 Controlled substances *listed* in schedules I and II shall be distributed by a registrant to another registrant only pursuant to an order form [.] *and may be received by a registrant only pursuant to an order form.* Compliance with the provisions of federal law respecting order forms shall be deemed compliance with this section.

SEC. 5. NRS 453.258 is hereby amended to read as follows:

453.258 A record of each refill of any prescription for a controlled substance listed in schedule III, IV or V, or any authorization to refill such a prescription, shall be kept on the back of the original prescription. Such record shall show the date of each refill or authorization, *the number of dosage units* and the name or initials of the pharmacist who refilled such prescription or obtained the authorization to refill.

SEC. 6. NRS 453.381 is hereby amended to read as follows:

453.381 1. [A] *Except as otherwise prohibited in this subsection, a* physician, dentist or podiatrist, in good faith and in the course of his professional practice or as directed by the health division of the department of human resources at a certified hospital or at a rehabilitation clinic, may prescribe, administer and dispense controlled substances, or he may cause the same to be administered by a nurse or interne under his direction and supervision.

[2.] *Except in cases of emergency or serious illness, a physician, dentist or podiatrist is prohibited from prescribing controlled substances listed in schedule II for himself, his spouse or children.*

2. Each prescription for a controlled substance listed in schedule II shall be written on a separate prescription blank.

3. A veterinarian, in good faith and in the course of his professional practice only, and not for use by a human being, may prescribe, administer, and dispense controlled substances, and he may cause them to be administered by an assistant or orderly under his direction and supervision.

[3.] *4.* Any person who has obtained from a physician, dentist, podiatrist or veterinarian any controlled substance for administration to a patient during the absence of such physician, dentist, podiatrist or veterinarian shall return to such physician, dentist, podiatrist or veterinarian any unused portion of such substance when it is no longer required by the patient.

1977

Senate Bill No. 467—Committee on Commerce and Labor

CHAPTER 371

AN ACT relating to physicians' assistants; authorizing the state board of pharmacy to issue registration certificates to physicians' assistants for the possession, administration and dispensing of controlled substances, poisons, dangerous drugs and devices; providing for registration fees and the suspension and revocation of registration certificates; requiring the adoption of regulations by the state board of pharmacy; and providing other matters properly relating thereto.

[Approved May 5, 1977]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. Chapter 639 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. A physician's assistant may, if authorized by the board, possess, administer or dispense controlled substances, poisons, dangerous drugs or devices in or out of the presence of his supervising physician only to the extent and subject to the limitations specified in the physician's assistant's certificate as issued by the board.

2. Each physician's assistant who is authorized by his physician's assistant's certificate issued by the state board of medical examiners to possess, or administer or dispense controlled substances, or poisons, or dangerous drugs or devices must apply for and obtain a registration certificate from the board and pay a fee to be set by regulations adopted by the board before he can possess, administer or dispense controlled substances, poisons, dangerous drugs or devices.

3. The board shall consider each application separately and may,

EXHIBIT

even though the physician's assistant's certificate issued by the state board of medical examiners authorizes the physician's assistant to possess, administer or dispense controlled substances, poisons, dangerous drugs and devices:

(a) Refuse to issue a registration certificate;

(b) Issue a registration certificate limiting the physician's assistant's authority to possess, administer or dispense controlled substances, poisons, dangerous drugs or devices, the area in which the physician's assistant may possess controlled substances, poisons, dangerous drugs and devices, or the kind and amount of controlled substances, poisons, dangerous drugs and devices; or

(c) Issue a registration certificate imposing other limitations or restrictions which the board feels are necessary and required to protect the health, safety and welfare of the public.

4. If the registration of the physician's assistant is suspended or revoked, the physician's controlled substance registration may also be suspended or revoked.

5. The board shall adopt regulations controlling the maximum amount to be administered, possessed and dispensed, and the storage, security, recordkeeping and transportation of controlled substances, poisons, dangerous drugs and devices by physicians' assistants. In the adoption of such regulations, the board shall consider, but is not limited to, the following:

(a) The area in which the physician's assistant is to operate;

(b) The population of that area;

(c) The experience and training of the physician's assistant;

(d) The distance to the nearest hospital and physician; and

(e) The effect on the health, safety and welfare of the public.

SEC. 2. NRS 453.021 is hereby amended to read as follows:

453.021 "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the b dy of a patient or research subject by:

1. A practitioner or, in his presence, by his authorized agent;
2. A licensed nurse, at the direction of a physician; [or]
3. The patient or research subject at the direction and in the presence of the practitioner [.] *; or*
4. *A physician's assistant, if authorized by the board.*

SEC. 3. NRS 453.056 is hereby amended to read as follows:

453.056 A controlled substance or drug is "dispensed" if it is delivered to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, or is furnished to an ultimate user personally by a physician, *physician's assistant if authorized by the board,* dentist or podiatrist in any amount greater than that which is necessary for the present and immediate needs of the user. Dispensing includes the prescribing, administering, packaging, labeling or compounding necessary to prepare the substance for that delivery.

SEC. 4. NRS 454.191 is hereby amended to read as follows:

454.191 "Administer" means the furnishing:

1. By a physician, *physician's assistant if authorized by the board,* surgeon, dentist, podiatrist or veterinarian to his patient of such amount

of drugs or medicines referred to in NRS 454.181 to 454.381, inclusive, as are necessary for the immediate needs of the patient; or

2. By a nurse pursuant to a chart order of individual doses of a drug or medicine:

(a) From an original container which has been furnished as floor or ward stock by a hospital pharmacy;

(b) From a container dispensed by a registered pharmacist pursuant to a prescription; or

(c) Furnished by a physician, dentist, podiatrist or veterinarian.

SEC. 5. NRS 454.211 is hereby amended to read as follows:

454.211 "Dispense" means the furnishing of:

1. Drugs by a registered pharmacist upon the legal prescription from a physician, dentist, podiatrist or veterinarian; or

2. Drugs or medicines to a patient personally by a physician, *physician's assistant if authorized by the board,* dentist, podiatrist or veterinarian in any amount greater than that which is necessary for the present and immediate needs of the patient.

SEC. 6. NRS 454.221 is hereby amended to read as follows:

454.221 1. Any person who furnishes any dangerous drug except upon the prescription of a physician, dentist, podiatrist or veterinarian is guilty of a gross misdemeanor, unless the dangerous drug was obtained originally by a legal prescription.

2. The provisions of this section do not apply to the furnishing of any dangerous drug by a physician, *physician's assistant if authorized by the board,* dentist, podiatrist or veterinarian to his own patients as provided in NRS 454.301 or by a manufacturer or wholesaler or pharmacy to each other or to a physician, dentist, podiatrist or veterinarian or to a laboratory under sales and purchase records that correctly give the date, the names and addresses of the supplier and the buyer, the drug and its quantity.

Senate Bill No. 447—Senators Blakemore and Hernstadt

CHAPTER 372

AN ACT relating to motor vehicle salesmen; changing certain provisions for the licensing of such salesmen; and providing other matters properly relating thereto.

[Approved May 5, 1977]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 482.362 is hereby amended to read as follows:

482.362 1. Except as provided in NRS 482.324, no person may engage in the activity of a vehicle, trailer or semitrailer salesman in the State of Nevada without first having received a license from the department. Before issuing a license to engage in the activity of a salesman, the department shall require:

EXHIBIT

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3.2.

Senate Bill No. 89—Committee on Commerce and Labor

CHAPTER 272

AN ACT relating to architects; requiring firms, partnerships, corporations and associations practicing as architects to have a registered architect in residence responsible for the administration of the work under certain circumstances; and providing other matters properly relating thereto.

[Approved April 24, 1975]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 623.350 is hereby amended to read as follows:

623.350 *1.* Nothing in this chapter shall be construed as preventing firms, partnerships, corporations or associations of architects and engineers from practicing as such, provided each member of such firm, partnership, *corporation* or association is registered under the provisions of this chapter or chapter 625 of NRS.

2. Every office or place of business of any firm, partnership, corporation or association engaged in the practice of architecture shall have an architect holding a certificate of registration issued under this chapter in residence and directly responsible for the administration of the architectural work conducted in such office or place of business.

3. The provisions of subsection 2 do not apply to firms, partnerships, corporations or associations engaged in the practice of architecture at offices established for construction administration.

1975 LAWS

Senate Bill No. 213—Committee on Judiciary

CHAPTER 273

AN ACT relating to dangerous drugs; increasing the penalty for furnishing a dangerous drug without a prescription; providing an exception; requiring a pharmacist to sign his name or initials on a record for each refill of a prescription for a dangerous drug; and providing other matters properly relating thereto.

[Approved April 24, 1975]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 454.221 is hereby amended to read as follows:

454.221 1. [No person shall furnish] *Any person who furnishes* any dangerous drug except upon the prescription of a physician, dentist, podiatrist or veterinarian [.] *is guilty of a gross misdemeanor, unless the dangerous drug was obtained originally by a legal prescription.*

2. The provisions of this section do not apply to the furnishing of any dangerous drug by a physician, dentist, podiatrist or veterinarian to his own patients as provided in NRS 454.301 or by a manufacturer or wholesaler or pharmacy to each other or to a physician, dentist, podiatrist or veterinarian or to a laboratory under sales and purchase records that correctly give the date, the names and addresses of the supplier and the buyer, the drug and its quantity.

SEC. 2. NRS 454.271 is hereby amended to read as follows:

454.271 A record of each refill of any prescription for a dangerous drug or any authorization to refill such a prescription shall be kept on the back of the original prescription, or on a separate card or paper securely attached thereto, showing the date of each refill or authorization and [the name or initials of] *shall be signed or initialed by* the pharmacist who refilled the prescription or obtained the authorization to refill.

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Assembly Bill No. 137—Committee on Agriculture

CHAPTER 274

AN ACT relating to brands and marks; establishing new periods for rerecording brands and marks; and providing other matters properly relating thereto.

[Approved April 25, 1975]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 564.120 is hereby amended to read as follows:

564.120 1. Any owner of a brand or brand and mark or marks of record under the provisions of NRS 564.010 to 564.150, inclusive, including brands or marks transferred under the terms of NRS 564.110, desiring legally to continue the use of the same beyond the prescribed dates shall, within [60 days prior to January 1, 1926, and within] 60 days prior to January 1, *1976, and* at the end of each [5-year] *4-year* period thereafter, make application to the department for the rerecording of the same.

2. The application shall be made in writing and accompanied by any rerecording fee set by the department in accord with the provisions of NRS 564.080.

3. The department shall notify every owner of a brand or brand and mark or marks of legal record in its office, including owners of brands and marks transferred under the provisions of NRS 564.110, at least 60 days prior to January 1, [1926,] *1976,* and January 1 at the end of each [5-year] *4-year* period thereafter, of his right to rerecord the same as provided in this section. The notice shall be in writing and shall be sent by mail to each such owner at his last address of record in the office of the department. Such notice shall be complete at the expiration of 60 days from the date of its mailing by the department.

4. The department may also advertise the approach of any rerecording period in such manner and at such times as it deems advisable.

5. Any or all brands or brands and marks for the rerecording of which the owners have not applied as provided for in this section by January 1, [1926,] *1976,* or by January 1 of any [5-year] *4-year*

EXHIBIT

5. The state planning board shall not be required to advertise for sealed bids for construction projects the estimated cost of which is less than $5,000, but the state planning board may solicit firm written bids from not less than two licensed contractors doing business in the area and may thereafter award the contract to the lowest bidder or reject all bids.

SEC. 21. 1. Section 19 of this act shall become effective July 1, 1973.

2. All other sections of this act shall become effective upon passage and approval.

Senate Bill No. 643—Committee on Finance

CHAPTER 669

AN ACT extending the term of lease of building used by the department of health, welfare and rehabilitation; and providing other matters properly relating thereto.

[Approved April 27, 1973]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. The buildings and grounds division of the department of administration is hereby authorized to extend the existing lease of the building used by the department of health, welfare and rehabilitation at 700 Belrose Street, Las Vegas, from 7 to 20 years, upon such terms and conditions as the parties may agree.

SEC. 2. This act shall become effective upon passage and approval.

Senate Bill No. 612—Committee on Transportation

CHAPTER 670

AN ACT to amend NRS 486.231, relating to safety equipment for motorcyclists, by exempting certain motorcyclists and passengers from requirement that protective headgear be worn.

[Approved April 27, 1973]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 486.231 is hereby amended to read as follows:

486.231 1. The department of motor vehicles shall adopt standards for protective headgear and protective glasses, goggles or face shields to be worn by the drivers and passengers of motorcycles and transparent windscreens for motorcycles.

2. Except as provided in [subsections 3 and 4,] *this section*, when any motorcycle is being driven on a highway, the driver and passenger shall wear protective headgear securely fastened on the head and protective glasses, goggles or face shields meeting such standards.

3. When a motorcycle is equipped with a transparent windscreen meeting such standards, the driver and passenger are not required to wear glasses, goggles or face shields.

4. When a motorcycle is being driven in a parade authorized by a local authority, the driver and passenger are not required to wear the protective devices provided for in this section.

5. *When a three-wheel motorcycle, on which the driver and passengers ride within an enclosed cab, is being driven on a highway, the driver and passengers are not required to wear the protective devices required by this section.*

Senate Bill No. 647—Committee on Finance

CHAPTER 671

AN ACT making appropriations to the division of water resources of the department of conservation and natural resources for certain legal fees and expenses arising out of actions concerning water rights in the Truckee River.

[Approved April 27, 1973]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. There is hereby appropriated from the general fund in the state treasury the sum of $100,000 to the division of water resources of the department of conservation and natural resources for the purpose of paying legal fees, court costs and other costs heretofore incurred or to be incurred in defending legal proceedings against the State of Nevada concerning the adjudication of water rights in the Truckee River.

SEC. 2. This act shall become effective upon passage and approval.

1973 Laws

Senate Bill No. 341—Committee on Judiciary

CHAPTER 672

AN ACT relating to dangerous drugs; regulating the delivery, possession and use of dangerous drugs; providing a penalty; and providing other matters properly relating thereto.

[Approved April 27, 1973]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 454.0092 is hereby amended to read as follows:

454.0092 "Manufacturer" means a person, other than a registered pharmacist practicing in a licensed pharmacy, *who derives, produces, prepares, compounds, mixes, cultivates, grows or processes any drug,*

EXHIBIT

repackages any drug for the purpose of resale, or who makes, produces or prepares any hypodermic or prophylactic device.

SEC. 2. NRS 454.0094 is hereby amended to read as follows:

454.0094 "Pharmacy" means every store or shop licensed under the provisions of chapter 639 of NRS where prescriptions are compounded and dispensed and *dangerous drugs,* poisons, medicines or chemicals are stored or possessed, or dispensed, sold or displayed at retail.

SEC. 3. NRS 454.0098 is hereby amended to read as follows:

454.0098 "Wholesaler" means a person who supplies *dangerous drugs,* chemicals or hypodermic or prophylactic devices that he himself has not derived, produced, repackaged or prepared, on sales orders for resale but not on prescriptions, except a nonprofit cooperative agricultural organization which supplies or distributes drugs and medicines only to its own members.

SEC. 4. Chapter 454 of NRS is hereby amended by adding thereto the provisions set forth as sections 5 to 41, inclusive, of this act.

SEC. 5. *"Chart order" is an order entered on the chart or medical record of a patient registered in a convalescent care facility or hospital or under emergency treatment in a hospital by or on the order of an authorized practitioner authorizing the administration of a drug from hospital floor or ward stock furnished by the hospital pharmacy. Any such order shall be considered to be a prescription if such medication is to be furnished by a pharmacy directly to the patient. The chart order shall be signed by the prescriber at the time it is entered or on his next visit to the hospital.*

SEC. 6. *"Laboratory" means a research, teaching or testing laboratory not engaged in the sale of drugs but using dangerous drugs for scientific or teaching purposes.*

SEC. 7. *"Prescription" means an order given individually for the person for whom prescribed, directly from the prescriber to the pharmacist or indirectly by means of an order signed by the prescriber, and shall contain the name and address of the prescriber, his license classification, the name and address of the patient, the name and quantity of the drug or drugs prescribed, directions for use and the date of issue. Directions for use shall be specific in that they shall indicate the portion of the body to which the medication is to be applied or, if to be taken into the body by means other than orally, the orifice or canal of the body into which the medication is to be inserted or injected.*

SEC. 8. *Definitions of words and terms in sections 9, 10 and 11 of this act apply only to sections 8 to 41, inclusive, of this act.*

SEC. 9. *"Administer" means the furnishing:*

1. By a physician, surgeon, dentist, podiatrist or veterinarian to his patient of such amount of drugs or medicines referred to in sections 8 to 41, inclusive, of this act, as are necessary for the immediate needs of the patient; or

2. By a nurse pursuant to a chart order of individual doses of a drug or medicine:

(a) From an original container which has been furnished as floor or ward stock by a hospital pharmacy;

(b) From a container dispensed by a registered pharmacist pursuant to a prescription; or

(c) Furnished by a physician, dentist, podiatrist or veterinarian.

SEC. 10. *"Dangerous drug" means any drug, other than a controlled substance as defined in chapter 453 of NRS, unsafe for self-medication or unsupervised use, and includes the following:*

1. Any drug which has been approved by the Food and Drug Administration for general distribution and bears the legend: "Caution: Federal law prohibits dispensing without prescription"; or

2. Any drug which may be sold only by prescription because of regulations adopted by the board because the board has found such drugs to be dangerous to public health or safety.

SEC. 11. *"Dispense" means the furnishing of:*

1. Drugs by a registered pharmacist upon the legal prescription from a physician, dentist, podiatrist or veterinarian; or

2. Drugs or medicines to a patient personally by a physician, dentist, podiatrist or veterinarian in any amount greater than that which is necessary for the present and immediate needs of the patient.

NRS 454.221

SEC. 12. *1. No person shall furnish any dangerous drug except upon the prescription of a physician, dentist, podiatrist or veterinarian.*

2. The provisions of this section do not apply to the furnishing of any dangerous drug by a physician, dentist, podiatrist or veterinarian to his own patients as provided in section 28 of this act or by a manufacturer or wholesaler or pharmacy to each other or to a physician, dentist, podiatrist or veterinarian or to a laboratory under sales and purchase records that correctly give the date, the names and addresses of the supplier and the buyer, the drug and its quantity.

SEC. 13. *No pharmacist shall dispense any dangerous drug upon prescription except in a container correctly labeled with:*

1. The date;

2. The name, address and prescription number of the pharmacy;

3. The names of the prescriber and of the person for whom prescribed;

4. Specific directions for use given by the prescriber; and

5. The expiration date of the effectiveness of the drug dispensed, if such information is required on the original label of the manufacturer of such drug.

SEC. 14. *No pharmacist shall knowingly fill or refill any prescription for a dangerous drug for use by any person other than the one for whom the prescription was originally issued.*

SEC. 15. *No prescription for any dangerous drug may be refilled except in compliance with the provisions of sections 16 to 23, inclusive, of this act.*

SEC. 16. *A prescription which bears specific refill authorization, given by the prescriber at the time he issued the original prescription, may be refilled in the pharmacy in which it was originally filled, for the number of times authorized or over the period of time authorized, but only in keeping with the number of doses ordered and the directions for use; but in no case shall the prescription be refilled after 1 year has elapsed from the date it was originally filled. If additional medication*

EXHIBIT

59 15

is needed thereafter, the original prescription shall be voided and a new prescription obtained.

SEC. 17. *A prescription which bears authorization, permitting the pharmacist to refill the prescription as needed by the patient, may be refilled in keeping with the number of doses ordered and the directions for use within 1 year from the date it was originally filled.*

SEC. 18. *An original prescription which does not bear refill authorization, or a prescription on which the original refill authorization has expired, may be refilled if additional authorization has been obtained from the prescriber or another doctor with the same license classification acting in the absence of the original prescriber. Such information may be relayed to the pharmacist by an authorized agent employed by the prescriber, if the prescriber, or another doctor acting in his absence, is available and is contacted by the authorized agent.*

SEC. 19. *A physician may issue a blanket authorization individually to any pharmacist authorizing such pharmacist to refill prescriptions written by the physician, for drugs which are considered necessary in the treatment of chronic or continuing illnesses of his patients. Such authorization shall be in writing, signed by the physician, and shall list the types of drugs to be covered and any limitations or conditions the physician may desire. Such authorization shall be retained by the pharmacist and available for inspection and shall be valid authorization for the pharmacist to refill such prescriptions for a period of 1 year from the date of issue.*

SEC. 20. *In the absence of specific refill authorization, when the refilling of a prescription calling for a dangerous drug needed for the continuation of a treatment of a chronic or continuing illness is considered necessary and the pharmacist is unable to contact the prescriber, the pharmacist may, if in his professional judgment he feels that such drug should be provided for the patient, furnish a sufficient supply of the medication to provide for the continuation of treatment until such time as the prescriber can be personally contacted.*

SEC. 21. *No prescription for a dangerous drug may be refilled after the demise of the prescriber.*

SEC. 22. *A record of each refill of any prescription for a dangerous drug or any authorization to refill such a prescription shall be kept on the back of the original prescription, or on a separate card or paper securely attached thereto, showing the date of each refill or authorization and the name or initials of the pharmacist who refilled the prescription or obtained the authorization to refill.*

SEC. 23. *Any refill authorization issued pursuant to the provisions of sections 16 to 22, inclusive, of this act, may be rescinded at any time after such authorization is given, either by the original prescriber or by another doctor acting in his behalf or by another doctor who is then caring for the patient for whom the original prescription was issued, by notifying the pharmacy in which the prescription was filled either orally or in writing.*

SEC. 24. *1. Every laboratory, manufacturer and wholesaler doing business in the State of Nevada shall be registered with the board.*

2. Each laboratory shall keep purchase records.

3. Each manufacturer shall keep purchase and use records and sales records.

4. Each wholesaler shall keep purchase and sales records.

SEC. 25. *1. Every retail pharmacy, hospital, laboratory, wholesaler, manufacturer, or any physician, dentist, podiatrist or veterinarian who engages in the practice of dispensing or furnishing drugs to patients shall maintain a complete and accurate record of all dangerous drugs purchased and those sold on prescription, dispensed, furnished or disposed of otherwise.*

2. Such records shall be retained for a period of 2 years and shall be open to inspection by members, inspectors or investigators of the board or inspectors of the Food and Drug Administration. No special form of record is required if an accurate accountability can be furnished within a reasonable time after a demand by a person authorized to inspect such records.

3. Invoices showing all purchases of dangerous drugs shall be considered as a complete record of all dangerous drugs received.

4. For the purpose of this section, the prescription files of a pharmacy shall constitute a record of the disposition of all dangerous drugs.

SEC. 26. *1. All stock and records of purchase and disposition of any dangerous drug of a manufacturer, wholesaler, pharmacy, physician, dentist, podiatrist, veterinarian, hospital, laboratory or a nonprofit cooperative agriculture organization which supplies and distributes drugs and medicines only to its members shall be at all times, during business hours, open to inspection by agents, assistants, members and inspectors of the board, inspectors of the Food and Drug Administration, and agents and commissioners appointed under chapter 585 of NRS for the enforcement of the Nevada Food, Drug and Cosmetic Act. Such records shall be preserved for at least 2 years from the date of making.*

2. Any person who fails, neglects or refuses to maintain such records or who, when called upon by an authorized officer to produce such records, fails, neglects or refuses to produce such records, or who willfully produces or furnishes records which are false, is guilty of a misdemeanor.

SEC. 27. *All agents, assistants and inspectors of the board and peace officers, while investigating violations of sections 8 to 41, inclusive, of this act, in performance of their official duties, and any person working under their immediate direction, supervision or instruction are immune from prosecution under sections 8 to 41, inclusive, of this act.*

NRS 454.321 SEC. 28. *1. The provisions of sections 8 to 41, inclusive, of this act, do not apply to a physician, dentist, podiatrist or veterinarian who dispenses drugs and who personally furnishes his own patients with such drugs as are necessary in the treatment of the condition for which he attends such patient, if:*

(a) He keeps accurate records, as required by section 25 of this act, of all drugs so furnished; and

(b) The drugs so furnished are clearly labeled with the date, the name and address of the furnisher, the name of the patient, the directions for

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EXHIBIT

use and the expiration date of the effectiveness of the drug, if such information is required on the original label of the manufacturer of such drug; and

(c) Such drugs are not dispensed or furnished by a nurse or attendant.

2. A veterinarian may furnish multiple doses of drugs, necessary for the treatment of large animals, to ranchers or dealers in livestock for use solely in the treatment of livestock on the premises of such rancher or dealer, and when furnishing such drugs the veterinarian is not required to comply with the provisions of subsection 1.

SEC. 29. *Every person who violates any provision of sections 8 to 41, inclusive, of this act, by use of a minor as an agent or by unlawfully furnishing any dangerous drug to a minor shall be punished by imprisonment in the state prison for not less than 1 year nor more than 10 years, or by a fine of not more than $5,000, or by both fine and imprisonment.*

SEC. 30. *1. Every person who signs the name of another, or of a fictitious person, or falsely makes, alters, forges, utters, publishes or passes, as genuine, any prescription for a dangerous drug is guilty of a felony.*

2. Any person who knowingly has in his possession any false, fictitious, forged or altered prescription for a dangerous drug is guilty of a gross misdemeanor.

3. Every person who knowingly obtains or has in his possession or under his control any dangerous drug secured as a result of any forged, false, fictitious or altered prescription is guilty of a gross misdemeanor.

NRS 454.316 SEC. 31. *1. Except as otherwise provided in this section, every person who possesses any drug defined in section 10 of this act, except that furnished to such person by a pharamacist pursuant to a legal prescription or a physician, dentist, podiatrist or veterinarian, is guilty of a gross misdemeanor. If such person has been twice previously convicted of any offense:*

(a) Described in this section; or

(b) Under any other law of the United States or this or any other state or district which if committed in this state would have been punishable as an offense under this section,

he shall be punished by imprisonment in the state prison for not less than 1 year nor more than 10 years.

2. No prescription is required for possession of such drugs by pharmacists, physicians, dentists, podiatrists, veterinarians, jobbers, wholesalers, manufacturers or laboratories authorized by laws of this state to handle, possess and deal in such drugs when such drugs are in stock containers properly labeled and have been procured from a manufacturer, wholesaler or pharmacy, or by a rancher who possesses such dangerous drugs in a reasonable amount for use solely in the treatment of livestock on his own premises.

SEC. 32. *1. Anyone authorized by the provisions of section 28 of this act, to dispense drugs to his own patients who permits the dispensing or furnishing of any dangerous drug in violation thereof is guilty of a misdemeanor.*

2. Any person who dispenses or furnishes any dangerous drug in violation of section 28 of this act is guilty of a misdemeanor.

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57

SEC. 33. *Every person who, in order to obtain any dangerous drug, falsely represents himself in a telephone conversation with a pharmacist to be a physician or other person who can lawfully prescribe such drugs or to be acting in behalf of a person who can lawfully prescribe drugs is:*

1. For the first offense, guilty of a misdemeanor.

2. For any subsequent offense, guilty of a felony.

SEC. 34. *It is unlawful for any person within this state to possess, sell, offer to sell or hold for the purpose of sale or resale any nasal inhaler which contains any drug capable of causing stimulation to the central nervous system unless:*

1. The product contains a denaturant in sufficient quantity to render it unfit for internal use; and

2. The product is among such products listed as approved for sale without restriction by the board in the regulations officially adopted by the board.

SEC. 35. *1. Any person within this state who possesses, procures, obtains, processes, produces, derives, manufactures, sells, offers for sale, gives away or otherwise furnishes any drug which may not be lawfully introduced into interstate commerce under the Federal Food, Drug and Cosmetic Act is guilty of a misdemeanor.*

2. The provisions of this section do not apply to physicians licensed to practice in this state who have been authorized by the Food and Drug Administration to possess experimental drugs for the purpose of conducting research to evaluate the effectiveness of such drugs and who maintain complete and accurate records of the use of such drugs and submit clinical reports as required by the Food and Drug Administration.

SEC. 36. *Except as otherwise specifically provided, every person who violates any provision of sections 8 to 41, inclusive, of this act, is guilty of a misdemeanor.*

SEC. 37. *A conviction of the violation of any of the provisions of sections 8 to 41, inclusive, of this act, constitutes grounds for the suspension or revocation of any license issued to such person under any of the provisions of chapters 630, 631, 633, 635, 638 or 639 of NRS.*

SEC. 38. *The board shall administer and enforce sections 8 to 41, inclusive, of this act.*

SEC. 39. *1. If the board finds any drug to be dangerous to the public health or safety, it may make other rules, not inconsistent with sections 8 to 41, inclusive, of this act, limiting or restricting the furnishing of such drug. The proceedings for adoption of such rules shall be governed by chapter 233B of NRS.*

2. A violation of any such rule shall be punished in the same manner as is provided in sections 29 to 36, inclusive, of this act.

SEC. 40. *Notice of the adoption of further rules by the board shall be given to interested persons. No person shall be subject to any prosecution for violating such rules until the board has given public notice of the adoption of such rules.*

SEC. 41. *Upon request, the board shall furnish any person with a copy of the laws or regulations relating to dangerous drugs, the furnishing*

EXHIBIT

or possession of which is restricted by sections 8 to 41, inclusive, of this act, or by further rules of the board.

SEC. 42. NRS 454.480 is hereby amended to read as follows:

454.480 1. Hypodermic devices may be sold by pharmacists on the prescription of a physician, dentist or veterinarian. Such prescriptions shall be filed as required by NRS 639.236, and may be refilled as authorized by the prescriber. Records of refilling shall be maintained as required by [NRS 453.441 to 453.521, inclusive.] *sections 15 to 23, inclusive, of this act.*

2. Pharmacists and others holding hypodermic permits, unless the permit limits otherwise, may sell hypodermic devices without prescription for the following purposes:

(a) For use in the treatment of persons having asthma or diabetes.

(b) For use in injecting medications prescribed by a physician for the treatment of human beings.

(c) For the injection of drugs in animals or poultry.

(d) For commercial or industrial use or use by jewelers or other merchants having need for such devices in the conduct of their business, or by hobbyists when the seller is satisfied that the device will be used for legitimate purposes.

(e) For use by funeral directors and embalmers, licensed medical technicians or technologists, or research laboratories.

3. The sale without prescription of any hypodermic device intended for human use, as set forth in paragraphs (a) and (b) of subsection 2, shall be limited to pharmacists and all such sales must be recorded as provided in NRS 454.490.

SEC. 43. NRS 454.534 is hereby amended to read as follows:

454.534 In any complaint, information or indictment and in any action or proceeding brought for the enforcement of any provision of NRS 454.470 to 454.530, inclusive, *and sections 8 to 41, inclusive, of this act,* it shall not be necessary to negative any exception, excuse, proviso or exemption contained in NRS 454.470 to 454.530, inclusive, *and sections 8 to 41, inclusive, of this act,* and the burden of proof of any such exception, excuse, proviso or exemption shall be upon the defendant.

SEC. 44. NRS 454.535 is hereby amended to read as follows:

454.535 The amount of a drug needed to sustain a conviction of a person for an offense prohibited by [NRS 454.180 to 454.465, inclusive,] *sections 8 to 41, inclusive, of this act,* is that amount necessary for identification as such drug by a witness qualified to make such identification for the prosecution and a witness qualified to make such identification for the defense.

SEC. 45. NRS 453.521 is hereby amended to read as follows:

453.521 It is unlawful for any person within this state to possess, sell, offer to sell or hold for the purpose of sale or resale any nasal inhaler which contains any controlled substance capable of causing stimulation to the central nervous system unless:

1. The product contains a denaturant in sufficient quantity to render it unfit for internal use; and

2. The product is among such products listed as approved by the

[division] *board* in the regulations officially adopted by the [division.] *board.*

SEC. 46. Section 45 of this act shall not become effective if section 25 of Senate Bill 342 of the 57th session of the Nevada legislature becomes law.

SEC. 47. This act shall become effective at 12:02 a.m. on July 1, 1973.

Senate Bill No. 342—Committee on Judiciary

CHAPTER 673

AN ACT relating to controlled substances; making technical changes; and providing other matters properly relating thereto.

[Approved April 27, 1973]

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 453.146 is hereby amended to read as follows:

453.146 1. The board shall administer [this chapter] *the provisions of NRS 453.011 to 453.551, inclusive,* and may add substances to or delete or reschedule all substances enumerated in the schedules in NRS 453.161, 453.171, 453.181, 453.191, and 453.201, pursuant to the procedures of chapter 233B of NRS.

2. In making a determination regarding a substance, the board shall consider the following:

(a) The actual or relative potential for abuse;

(b) The scientific evidence of its pharmacological effect, if known;

(c) The state of current scientific knowledge regarding the substance;

(d) The history and current pattern of abuse;

(e) The scope, duration and significance of abuse;

(f) The risk to the public health;

(g) The potential of the substance to produce psychic or physiological dependence liability; and

(h) Whether the substance is an immediate precursor of a substance already controlled under [this chapter.] *the provisions of NRS 453.011 to 453.551, inclusive.*

3. After considering the factors enumerated in subsection 2 the board shall make findings with respect thereto and issue a rule controlling the substance if it finds the substance has a potential for abuse.

4. If the board designates a substance as an immediate precursor, substances which are precursors of the controlled precursor shall not be subject to control solely because they are precursors of the controlled precursor.

5. If any substance is designated, rescheduled or deleted as a controlled substance under federal law and notice thereof is given to the

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EXHIBIT

TAB XII
EXHIBIT I

AMENDMENT TO AB580

NRS 636 Section 1 of AB580

The State Board of Optometry shall by regulation, with the advice and consent of the State Board of Medical Examiners and State Board of Pharmacy establish educational and examination requirements for licensure to insure the competence of optometrists to practice pursuant to NRS 636.025 (7). Satisfactory completion of the educational and examination requirements shall be a condition for the issuance of an original certificate of registration under this chapter, on and after January 1, 1980. Only those optometrists who have successfully completed educational and examination requirements as determined by the State Board of Optometry with the advice and consent of the State Board of Medical Examiners and State Board of Pharmacy shall be permitted the use of pharmaceutical agents specified by NRS 630.025 (7).

EXHIBIT

AMENDMENT TO AB580

PAGE 3, LINE 21

NRS. 636.025 Subdivision 7

The use of topical pharmaceutical agents for the sole purpose of the examination of the human eye or eyes for any disease or pathological condition. The State Board of Optometry, ~~with the advice and consent of~~ the State Board of Medical Examiners and State Board of Pharmacy, ~~to be provided within six months of the effective date of this section,~~ shall designate the specific topical pharmaceutical agents, known generically as mydriatics, cycloplegics, and topical anesthetics, to be used.

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CO.

EXHIBIT ___

AMENDMENT TO AB580

NRS 636.301 Subdivision 12

Acts of excessive prescribing or administering of drugs acts of excessive use of diagnostic procedures, or acts of clearly excessive use of diagnostic facilities as determined by the standard of the local community is unprofessional conduct for an optometrist.

EXHIBIT

AMENDMENT

NRS 636.301 Subdivision 13

Failure to refer the following persons to a medical practitioner for diagnosis and treatment whenever the optometrist notes:

(a) A failure on the part of the individual being examined to achieve 20/40 visual acuity in each eye by refraction, unless the cause of impaired vision has already been medically confirmed;

(b) A complaint by the individual being examined of flashes of light, floaters, haloes, transient dimming of vision obscurred vision or loss of vision;

(c) Double vision or excessive tearing;

(d) A complaint by the individual being examined of permanent or temporary loss of any part of the visual field or the clinical discovery of any such field loss, or;

(e) The presence of corneal opacities or abnormalities in the normally transparent media of the eye, the ocular fundus, or the disc not previously medically identified.

Exhibit J

Washoe County Medical Society

3660 BAKER LANE • RENO, NEVADA 89509 • (702) 825-0278

February 20, 1979

TO: Nevada State Legislators

FROM: Donald A. Molde, M.D., President

SUBJ: Proposed Changes in Optometric Law

By a unanimous vote, the Board of Directors of Washoe County Medical Society passed a resolution of support for the Nevada Opthalmological Society's position statement on the use of diagnostic drugs by optometrists.

Under the guise of expanding the health provider field, these practitioners, with limited licenses, would request of you the right to practice medicine without necessary training.

These non-medically trained individuals could well increase the cost of care through their lack of training and limited ability to make necessary diagnoses of diseases that may threaten an individual's eyesight or life.

We respectfully request that you reject any attempts to dilute the quality of health care in Nevada. With your help, your constituents will never be placed in the position of receiving medical eye care by non-medical practitioners.

DM:dar

AMA -

EXHIBIT J

ANNUAL CONVENTION, JUNE 27 - JULY 1, 1976

AMERICAN MEDICAL ASSOCIATION

9. RESOLUTION 76 — PRESCRIBING EYE MEDICATIONS

Resolution 76 asked that the AMA adopt the policy that only physicians licensed to practice medicine and surgery are qualified to prescribe or use eye medications and that they should be the primary entry point for eye care, and also asked that the AMA vigorously oppose any legislative or administrative attempt to give optometrists a license to prescribe or use medications or to serve as a primary entry point in the provision of eye services.

The House considered the following amended Substitute Resolution:

RESOLVED, That the American Medical Association reaffirm its policy that only physicians licensed to practice medicine and surgery in all its branches are qualified to prescribe or apply eye medications; and be it further

RESOLVED, That the American Medical Association continue to urge that state medical societies oppose any legislation or administrative attempt to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury; and be it further

RESOLVED, That the House of Delegates directs the attention of the constituent state societies to the position of the Association as stated in Resolution 169 (A-73).

SUBSTITUTE RESOLUTION 76 ADOPTED AS AMENDED

ANNUAL CONVENTION, JUNE 24 - 28, 1973

No. 169 REAFFIRMATION OF POSITION RELATIVE TO LEGISLATION AUTHORIZING DIAGNOSIS OF DISEASE

Introduced by Section on Ophthalmology
Harold F. Falls, M. D., Delegate
(Reference Committee B, page 412)

HOUSE ACTION: ADOPTED

RESOLVED, That the American Medical Association reaffirm that any legislation that would authorize optometrists to engage in the diagnosis or treatment of disease or injury, or the diagnosis of the absence of disease or injury, or to use drugs or medications in any form for any purpose is in conflict with the public interest, and that the Association urge constitutent societies unequivocally to oppose and to seek the defeat of any legislation that would extend the scope of optometry into these areas of the practice of medicine; and be it further

RESOLVED, That the constituent state societies be promptly informed by special communication of this action of the House, and that state societies where such legislation is now pending be officially informed without delay

EXHIBIT J

BULLETIN

May, 1978 of the Vol. 63 No. 5

AMERICAN COLLEGE OF SURGEONS

AMERICAN SURGEONS ABROAD:

Reports from Lebanon, Ethiopia, the USSR, and Vietnam — page 10

COLLEGE BRIEFS

College announces statement on use of drugs by optometrists

After receiving advice and counsel from the Board of Governors and the Advisory Council for Ophthalmic Surgery, the following statement has been approved by the Board of Regents of the American College of Surgeons:

"In the interest of maintaining a high standard of health care, the American College of Surgeons recommends that the diagnosis, management, and treatment of ocular diseases be carried out only by fully licensed practitioners of medicine.

"Further, the American College of Surgeons opposes legislation which permits the use of drugs for diagnosis and therapy by optometrists."

Prize-winning essay

The Georgia Chapter of the American College of Surgeons sponsored an essay competition for surgical residents from various surgical training programs within the state of Georgia in November of 1977. A $200 award was presented to Dr. Foad Nahai, resident in plastic and reconstructive surgery at Emory University. His paper was entitled "Free Transfer and Replantation of Composite Tissue by Microvascular Techniques."

EXHIBIT J

OPHTHALMOLOGY

TRANSACTIONS

AMERICAN ACADEMY of OPHTHALMOLOGY and OTOLARYNGOLOGY

Volume 81 NOVEMBER - DECEMBER 1976 Number 6

OP-993

WHEREAS, the AAOO has for 80 years directed its activities to the public interest, health, and welfare of the citizens of this country, and

WHEREAS, the AAOO is of the opinion that the use of prescription legend drugs by individuals not trained and licensed to practice medicine and surgery in all of its branches is detrimental to the health and welfare of the citizens of this country; therefore, be it

RESOLVED, that the AAOO is OPPOSED to all legislative authorization of individuals not licensed to practice medicine and surgery in all of its branches to use prescription legend drugs for either diagnostic or therapeutic purposes, or both.

The Association of University Professors of Ophthalmology, Inc.

EXHIBIT J

October 15, 1976

James L. McGraw, M.D.
Professor and Chairman
Department of Ophthalmology
College of Medicine
State University of New York
Upstate Medical Center
750 East Adams Street
Syracuse, New York 13210

Dear Dr. McGraw:

This letter is in response to your request for a statement of the position of the Association of University Professors of Ophthalmology, Inc. concerning the use of drugs by optometrists. The Trustees of the Association note that there are significant hazards in the use of drugs for diagnostic purposes and even greater hazards associated with the long term use of drugs for therapeutic purposes. The complications of the uses of ophthalmic drugs even as topical solutions, may occur in remote organ systems giving rise to serious symptoms and lead to medical diagnostic and therapeutic errors. The Trustees believe that only the complete medical education of a physician equips one to use drugs which will be absorbed systemically. The Trustees further believe that any non-physician using such drugs should be subject to the same civil and criminal penalties for their misuse as would be a physician.

Sincerely yours,

Jonathan D. Wirthschafter, M.D.
Secretary-Treasurer

JDW/ss

EXHIBIT J

AMERICAN ASSOCIATION OF OPHTHALMOLOGY EXECUTIVE OFFICES • 1100 - 17th STREET, N.W., WASHINGTON, D.C. 20036 • TELEPHONE (202) 833-3447

RESOLUTION

"WHEREAS, This Association is of the opinion that any legislative authority granted to independent non-medical practitioners to prescribe or to apply drugs is contrary to the public interest and a detriment to the health and welfare of the citizens of this country; be it

RESOLVED, That this Association is opposed to the legislative authorization of independent non-medical practitioners to prescribe or apply drugs for either diganostic or therapeutic purposes or both."

Adopted by the Board of Trustees of the American Association of Ophthalmology at its Annual Meeting held October 5, 1976 - Las Vegas, Nevada.

EXHIBIT J

THE OPHTHALMOLOGIST

PUBLISHED BY
AMERICAN ASSOCIATION OF OPHTHALMOLOGY

NOVEMBER/DECEMBER 1976

Resolution

"*Whereas*, This Association is of the opinion that any legislative authority granted to independent non-medical practitioners to prescribe or to apply drugs is contrary to the public interest and a detriment to the health and welfare of the citizens of this country; be it

Resolved, That this Association is opposed to the legislative authorization of independent non-medical practitioners to prescribe or apply drugs for either diagnostic or therapeutic purposes or both."

Resolution

"*Resolved*, That the Board of Trustees of the American Association of Ophthalmology go on record as supporting and encouraging those states which have begun actively public relations efforts; and be it further

Resolved, That the Board commends state public relations programs for assisting each of the various state programs and for demonstrating significant results in a short time, and feels that such efforts will compliment the National effort; and be it further

Resolved, That coordination and cooperation between the state programs be encouraged, and that the National program be directed to support state public relations programs where possible."

WSMA Adopts Important Resolution

The Washington State Medical Association recently adopted a resolution which affirms "that any legislation that would authorize optometrists to engage in the diagnosis or treatment of disease or injury or the diagnosis of the absence of disease or injury, or to perform any type of surgery, or to use drugs or medications in any form for any purpose, excepting when under the direct supervision of a licensed physician is in conflict with the public interest, and further, that the Washington State Medical Association shall actively oppose any legislation, the purpose of which is to direct or indirectly extend the right to practice medicine or surgery to optometrists, or in any way restrict or interfere with the proper practice of medicine and/or surgery by licensed physicians and surgeons." Similar resolutions have been adopted by other state medical societies.

Resolutions adopted by the A.M.A. House of Delegates urge that state medical societies oppose any legislation or administrative attempt to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury. Accordingly, more state medical societies have been taking an active role in opposing optometric drug proposals and it is expected that they will continue to do so when necessary.

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EXHIBIT J

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NEW YORK STATE CONSUMERS STRONGLY URGE POSTPONEMENT OF ANY ACTION UNTIL PUBLIC HEARINGS CAN BE HELD BASED ON SURVEY OF RESULTS IN STATES WHERE SUCH LAWS ARE IN EFFECT.

COPIES OF THIS MAILGRAM SENT TO NEWS MEDIA, TV, AND RADIO.

ROBERT H. WILSON, CHAIRMAN
AD HOC BLACK LEADERS COMMITTEE
(212) 724-7400

22:05 EST

MGMCOMP MGM

A copy of the above mailgram was sent to every member of the New York State Legislature.

3-20-78

STATEMENT ON SENATE BILL 126

Exhibit K

By

Albert N. Lemoine, M.D., F.A.C.S.

March 16, 1977

My name is Albert Lemoine, Jr. I have been licensed as a Physician and Surgeon by the State of Kansas since 1947. My specialty is Ophthalmology (the diagnosis and treatment of diseases of the eye and visual system). I was certified as a specialist by the American Board of Ophthalmology in December 1946.

Since July, 1950 I have been Professor and Chairman of the Department of Ophthalmology at the University of Kansas School of Medicine. Between 1950 and 1971 I spent somewhat more than fifty percent of my time in administration and teaching of paramedical personnel, nurses, undergraduate medical students, residents in ophthalmology and continuing education of physicians and ophthalmologists at the University of Kansas Medical Center and other medical schools and Postgraduate Courses in the United States. Since 1967 I have had experiences in the undergraduate and continuing education of optometrists. Since 1971 I have not operated or had a private practice, but have devoted full time to administration (for the most part in ophthalmology), teaching at all levels of

medical education and serving on local and national advisory committees.

The opinions expressed in the following pages are mine and not those of The University of Kansas, The University of Kansas College of Health Sciences or any other organization of which I am a member. They are based on observations and experiences of thirty years in the practice of Ophthalmology (the diagnosis and treatment of disease of the eye and visual system) and biomedical education. My educational experience has involved the teaching of ophthalmology to paramedical personnel, nurses, undergraduate medical and optometric students, residents in ophthalmology and other medical areas, and the continuing education of physicians, ophthalmologists and optometrists.

38925

Based on the history of the testimony in the hearings concerning the use of drugs by optometrists, there are in general, seven areas that are considered. I will state my opinion and conclusions in these seven areas, then make a brief summary.

I. THE TYPES OF DRUGS USED AND THE PURPOSE OF USE OF DRUGS BY OPTOMETRISTS.

I am in favor of the topical use of drugs for diagnostic purposes by optometrists, in specific, anesthetics, mydriatics and cycloplegics. I am unequivocally opposed to either the topical or systemic use of drugs by optometrists for

therapeutic purposes. I believe there should not be a "grandfather" clause permitting the optometrist use of drugs for diagnostic purposes. An examination should be required that involves the pharmacological action of drugs and, in particular, the clinical effects and side effects of these drugs. This is carefully stated and identified in Senate Bill 126 lines 0041 to 0044, under consideration by this committee.

II. THE RISK TO THE PATIENT, WHEN AN OPTOMETRIST USES TOPICAL DRUGS FOR DIAGNOSTIC PURPOSES, TO LIFE AND VISION.

In my personal experience, involving over one million outpatient and in-hospital examinations, a majority as the direct supervisor of students or residents in ophthalmology, I have never seen or heard of a death or critical side effect when topical anesthetics, mydriatics or cycloplegics have been used for diagnostic purposes. In addition, I have talked with numerous private practitioners of ophthalmology and colleagues who are directors of ophthalmology training programs, and as yet have been unable to find anyone that has seen or heard of a verified death from the topical use of drugs for diagnostic purposes. I am confident that somewhere there must have been a death or critical side effect, however, considering the millions of patients who have been given topical drugs for

Recognized Side effects

diagnostic purposes the risk is extremely low. Insofar as a threat to vision is concerned it is more difficult to obtain accurate data. The most common complication of the topical use of drugs for diagnostic purposes is the development of an epithelial corneal abrasion following the topical use of an anesthetic agent to measure the intra-ocular pressure, especially when using the Schiotz tonometer. Although this produces a limited period of blurred vision and pain, I have never seen nor heard of permanent visual damage. This must not be confused with the development of a corneal ulcer following the topical use of an anesthetic agent to remove a foreign body of the cornea. In this latter situation the drug is being used for therapeutic and not diagnostic purposes. Section 1 prohibits the use of drugs or surgery for therapeutic purposes, lines 0036 to 0038. If the drug is used for therapeutic purposes it then becomes a matter for the courts to provide the control and punishment as is true in any other infraction of state statutes. Probably the most serious threat to visual loss is angle closure glaucoma following pupil dilatation. It is unusual for blindness or serious visual loss to result from acute angle closure glaucoma, if the correct diagnosis is made early and therapy is instituted. This diagnosis is not difficult, if one thinks of the possibility and especially if one

limits their practice to ocular problems. Section 1, lines 0038 to 0044 provides a reasonable protective mechanism where the optometrist must pass an examination considering the clinical side effects of the topical use of drugs for diagnostic purposes. The incidence of acute angle closure glaucoma following pupil dilatation is in the range of one person in forty to fifty thousand that have had their pupils dilated by topical or systemic medication. To my knowledge there are no other blinding conditions following the topical use of drugs for diagnostic purposes that occur with any significant frequency. One hears the complaint that there may be vision lost because an ocular condition such as glaucoma, uveitis, retinal separation, tumor, etc. has not been recognized after the topical use of drugs for diagnostic purposes have been used by an optometrist. To me this issue is not germane to the recommended legislative change. Drugs do not make ~~The use of drugs for diagnostic purposes does not make~~ a diagnosis, only the health care provider makes the diagnosis. An error in diagnosis and the failure of referral for definitive diagnosis and/or therapy is an entirely different situation. Once the optometrist uses drugs to aid in the diagnosis of ocular pathology, in my opinion he is bound by the same responsibilities as any other health care provider using drugs for the

same purpose. The fact that the health care provider is an optometrist in no way should relieve him of this diagnostic responsibility.

III. BENEFITS OF O.D.'S USING DRUGS FOR DIAGNOSTIC PURPOSES.

In my opinion the benefits that may result in the topical use of drugs by optometrists, for diagnostic purposes, far outweigh any dangers. Despite all new instrumentation there is no way to obtain a satisfactory view of the interior of the eye unless the pupil is dilated. I am unaware of anyone knowledgeable in the diagnosis of diseases behind the iris (the colored part of the eye) that would deny that pupil dilatation is necessary for accurate recognition of abnormalities or pathology. One area of controversy is the measurement of intraocular pressure by noncontact tonometry. In my opinion, the cost of the tonometer, approximately $4000, is not insignificant. More important is the fact that nearly all ophthalmologists will agree that in almost all patients the contact applanation tonometer is the most accurate and the instrument less costly.

IV. THE USE OF THE WORD DIAGNOSIS.

It is my opinion, that this one word causes more difficulty than all of the other issues concerning the topical use of drugs for diagnostic purposes. The basic problem is the failure of both optometrists

and ophthalmologists to recognize and accept the fact that they are not using the term diagnosis in the same manner. When one considers the broad spectrum of concepts where the term diagnosis may be correctly used, it is easy to understand this conflict. One can correctly use the term diagnosis for an abnormally functioning automobile engine, an economic crisis, political situation, etc. When a physician or an ophthalmologist uses the term diagnosis, it is in a very restrictive manner to describe a definitive abnormality of an organ or function, usually as the initial step in treatment or the ordering of other diagnostic tests on a particular patient. One of the most obvious examples of the confusion in definition is found in the diagnosis of glaucoma. In the vast majority of patients, the intraocular pressure will be increased (low tension glaucoma being an exception). The fundamental problem is agreement as to just what is an abnormal elevation of intraocular pressure and exactly what other parameters are significant, if the diagnosis of glaucoma is to be made in a particular patient. In my experience the average optometrist will use the term diagnosis in a broader manner, meaning the recognition of an ocular or visual abnormality that is an indication for referral for definite diagnosis and/or therapy. There is an area of

EXHIBIT K

overlap, such as refractive errors, muscle inbalance, muscle paralysis, etc. where both the optometrist and the ophthalmologist may make the same definitive diagnosis. To me the fact that an optometrist may use a diagnostic term such as glaucoma, iritis, papilledema, etc., without a modification, such as presumed, probable, possible, etc., is not bothersome. I believe the ophthalmologist has a serious obligation to the public to be actively involved with the undergraduate and continuing education of all eye health care providers, including optometrists, in the recognition of ocular or visual system problems requiring referral for definitive diagnosis and therapy, if needless blindness is to be avoided.

V. LEGISLATION PERMITTING OPTOMETRISTS TO USE TOPICAL DRUGS FOR DIAGNOSTIC PURPOSES IS THE FIRST STEP TOWARDS LATER LEGISLATION FOR OPTOMETRISTS TO USE DRUGS FOR THERAPY OR EVEN PERFORM SURGERY.

I fail to see that this objection is germane to the legislation under discussion because Section 1, lines 0036 to 0038 specifically state that drugs for therapy and surgery are not permitted. If at some later date legislation to use drugs for therapy, by optometrists, is considered an evaluation of the public welfare must be made at that time in view of new information and evaluation of optometrists. It

is true that legislation in West Virginia that permits optometrists to use topical drugs for both diagnosis and therapy has caused reason by non-optometrists to question the ultimate goal of optometry. This legislation, the section of therapy that I cannot accept as being for the public welfare, has caused ophthalmology and organized medicine to become more united in the opposition to any use of drugs by optometrists. I still believe that we must consider only the present legislation that prohibits therapy and not confuse this with some presumed future legislation.

VI. LEGISLATION PERMITTING THE TOPICAL USE OF DRUGS FOR DIAGNOSTIC PURPOSES BY OPTOMETRISTS WILL OPEN THE DOORS TO THE USE OF DRUGS BY NONPHYSICIANS.

It is obvious that this is not a significant statement because already legislation permits dentists and podiatrists to use drugs for both diagnosis and therapy. It is also true that in some states, nurse clinicians and physicians' assistants may prescribe drugs, change drugs and perform minor surgery. In each of the above instances, there has been significant alteration in the educational experiences of the health care provider. In all instances there are definite restrictions as to just what may be done and not

EXHIBIT K

an open license to practice medicine and surgery. Whether the future will bring changes in optometric education presenting the issue of therapy and surgery by optometrists only time will provide the answers. At present there is no justification for the inclusion of therapy or surgery by optometrists, but as stated previously this is not a factor in the legislation under consideration at this time.

VII. THE DISTRIBUTION OF OPTOMETRISTS AND OPHTHALMOLOGISTS.

One cannot ignore the fact that there are more than twenty thousand (20,000) optometrists in active practice in the United States today. In Kansas there are two hundred and sixty (260) optometrists in active practice in eighty five of one hundred and five counties. More than seventy percent (70%) practice outside Kansas City, Wichita and Topeka with eighty (80) practicing in fifty (50) communities on or west of 81 highway, excluding Wichita. There are seventy eight (78) ophthalmologists in the State of Kansas with fifty two percent (52%) practicing in Kansas City, Wichita and Topeka. There are eighteen (18) ophthalmologists in ten (10) communities on or west of 81 highway, excluding Wichita. It is obvious from this data that a majority of the citizens of Kansas receive their initial or total eye care from optometrists in the State of

EXHIBIT K

Kansas. As a faculty member at the University of Kansas School of Medicine, I am well aware of the critical shortage of health care providers in rural Kansas and the need to do all we can to obtain a better distribution of health care providers, as well as the best possible care from the present health care providers in rural Kansas.

The proposed legislation under consideration was the result of seven years of discussion by the members of the Kansas MD-OD Committee. The six optometric members of the committee are selected by the Kansas Optometric Association and the six ophthalmologists by the Eye Section of the Kansas Medical Society. In October, 1976 the MD-OD Committee, by a unanimous vote, recommended the proposed bill. At that time four of the ophthalmologists were in private practice in rural Kansas, one from Kansas City, Kansas and one faculty member from the University of Kansas School of Medicine. The Eye Section of the Kansas Medical Society, by a 27 to 14 vote, (78 ophthalmologists in the state) did not accept the proposed bill while a majority of the members of the Kansas Optometric Association did accept the proposed bill.

A significant factor that has evolved from the legislation under consideration is the role of the Department of Continuing Education at the University of Kansas College of Health Sciences in the continuing

EXHIBIT K

education of optometrists and primary care physicians in a course designed to recognize ocular problems where referral to an ophthalmologist is indicated. In the Fall of 1977 the first two day program will be given at the University of Kansas College of Health Sciences. The plan is that this course will be presented yearly.

Another important related factor has been the request by the Kansas Board of Optometric Examiners for ophthalmologists to provide questions to be used in the State Examination in the Spring of 1977. To me, these two factors, as well as the proposed legislation, point to a core group of both ophthalmologists and optometrists that are attempting to improve the eye health care in Kansas, especially in the rural area.

Following is a summary of the issues of the legislation under consideration in Senate Bill 126, as I perceive them:

I. The topical use of drugs, anesthetics, mydriatics and cycloplegics for diagnostic purposes by optometrists will be beneficial to the public welfare with minimal risk.

II. Section 1, lines 0038 to 0044, provide reasonable protection that by an examination optometrists will recognize side

EXHIBIT K

effects of drugs that require referral for definitive diagnosis and therapy.

III. Section 2, that clearly defines the delegation of data gathering by non-professionals, but decision making only by professionals will be of benefit to the public by making the professional more efficient in the use of his time.

IV. A related, but significant factor, will be the role of the ophthalmologist in the continuing education of the optometrist in the recognition of ocular abnormalities needing referral for definitive diagnosis and/or therapy by the Continuing Education Department of the University of Kansas College of Health Sciences.

In my opinion, the time has passed when we can retain the status quo and it behooves all of those involved (health care providers and members of the legislature) to carefully examine the facts and provide the best possible legislation for the public welfare at this time.

Respectfully submitted,

Albert N. Lemoine, M.D., F.A.C.S.

EXHIBIT K

Columbia University
School of Public Health

THE FACULTY OF MEDICINE
DIVISION OF HEALTH ADMINISTRATION

600 WEST 168th STREET
New York, N.Y. 10032

March 9, 1979

Honorable Senator William A. Hermstadt
Senator from Nevada
Legislative Council Building
Carson City, Nevada

Dear Senator Hermstadt:

I write this letter in my capacity as a Board Certified internist, as former Health Commissioner of the City of New York and as Professor of Public Health at the Columbia University School of Public Health.

I write to endorse most vigorously the legislation to expand the professional scope of optometry in order to encompass the use of diagnostic pharmaceutical agents for visual examinations.

The fact that other limited licensed health p·ofessionals such as dentists and podiatrists are permitted to use pharmaceutical agents, but optometrist are still forbidden to do so in Nevada represents an anachronistic constraint that unjustifiably limits vision care services. The certified formal educational program in pharmacology provides excellent preparation for optometrists to carry out these new responsibilities.

I regret to point out that the covert but no less real motivation why some MD physicians have rejected such legislation is economic rather than concern for visual care of the citizenry, particularly in rural areas where few to no MD ophthalmologists are geographically available. For an optometrist to be hindered, for example, from applying drops to dilate a patient's pupils in order to widen the field of observation of the retina, is contrary to the public health interests of the citizens of Nevada.

I find it extraordinary that there is still discussion about the relative merits of such legislation. For ophthalmologists to claim that optometrist, adequately trained in pharmacology, should not be allowed to use diagnostic eye drops because such drops may endanger the patient is incomparable presumption. May I call to the attention of public officials in Nevada that it is common practice for MD ophthalmologists to give eye drops to a mother with instructions to apply these drops to the child's eyes an hour before the oncoming appointment. Evidently the mother - possessing no pharmacology training and no education in physiology and optics - is no danger, but the optometrist is.

EXHIBIT "E"

I urge the State legislature of Nevada to pass this legislation and join the other states that already have done so.

Sincerely,

Lowell E. Bellin, M.D., M.P.H.
Professor of Public Health

LEB:emg

bcc: William G. Van Patten, OD
Box 1687
Carson City, Nevada

National Consumer Communications Program

1979 Television Schedule

AOA members are advised to check local listings for times in their areas. All air dates are subject to agency and/or network changes

Prime Time

PROGRAM	AIR DATE	NETWORK
"How the West Was Won"	February 5	ABC
"Barnaby Jones"	February 8	CBS
"Wonderful World of Disney"	February 11	NBC
"Paper Chase"	February 13	CBS
"Little Women"	February 15	NBC
"Little House on the Prairie"	February 26	NBC
"Vegas"	February 28	ABC
"Paper Chase"	March 6	CBS
"Rockford Files"	March 10	NBC
"One Day at a Time"	March 21	CBS
"Love Boat"	March 24	ABC
"The Waltons"	April 5	CBS
"Fantasy Island"	April 7	ABC

Daytime

"General Hospital"	February 7	ABC
"CBS Morning News"	February 8	CBS
"Days of Our Lives"	February 9	NBC
"CBS Morning News"	February 12	CBS
"General Hospital"	February 13	NBC
"Days of Our Lives"	February 13	CBS
"The Guiding Light"	February 14	ABC

PROGRAM	AIR DATE	NETWORK
"Wheel of Fortune"	February 14	NBC
"Family Feud"	February 16	ABC
"M.A.S.H."	February 16	CBS
"One Life To Live"	February 26	ABC
"CBS Morning News"	February 27	CBS
"Jeopardy"	February 28	NBC
"Love of Life"	March 2	CBS
"The Doctors"	March 5	NBC
"Jeopardy"	March 6	NBC
"$20,000 Pyramid"	March 14	ABC
"Edge of Night"	March 21	ABC
"CBS Morning News"	March 22	CBS
"Young and Restless"	March 22	CBS
"M.A.S.H."	March 22	CBS
"Another World"	March 23	NBC
"The Guiding Light"	April 2	CBS
"Wheel of Fortune"	April 2	NBC
"$20,000 Pyramid"	April 3	ABC
"Young and Restless"	April 4	CBS
"Edge of Night"	April 5	ABC
"Love of Life"	April 5	CBS
"Jeopardy"	April 6	NBC

PRIME-TIME = 170 MILLION HOUSEHOLDS

DAYTIME (FEMALE HOMEMAKER) 134 MILLION HOUSEHOLDS

Exhibit M

NEVADA STATE MEDICAL ASSOCIATION

NEIL SWISSMAN, M D , President
RICHARD C. INSKIP, M D., President-elect
GORDON L. NITZ, M D , Secretary-Treasurer
ROBERT L. BROWN, M D , Immed. Past President
LESLIE A. MOREN, M D., AMA Delegate
LEONARD H RAIZIN, M D , AMA Alternate Delegate
RICHARD G. PUGH, CAE, Executive Director

3660 Baker Lane • Reno, Nevada 89509 • (702) 825-6788

Testimony on A.B. 580

Chairman Wilson and distinguished members of the Senate Commerce Committee, I appreciate this opportunity to appear before you on behalf of Nevada physicians.

The Nevada State Medical Association is **opposed** to the use of legend drugs for the **diagnosis** and **treatment** of medical conditions by anyone other than trained physicians. We believe that anything to the contrary is not in the best interest of the citizens of our state.

We are asked to believe that A.B. 580 is aimed at correcting a previous legislative error denying this learned profession the use of diagnostic drugs previously in their armamentarium. I submit to you that this is not fact, but that A.B. 580 is aimed at an **expansion** of practice by persons not adequately trained in this area. This is witnessed by the fact this is not a Nevada problem but part of a national political thrust to change optometric practices. Testimony is offered by the supporters of this bill that it is now a statute in many states, and the number of those states is increasing daily. Hence, it can in no way be an attempt to correct Nevada's mistakes. Do not be mislead; it is part of a national political, not educational, expansion of the optometric practice. **We cannot legislate qualifications**, nor can these skills be learned in two weeks.

When medications are used by those not skilled in drug applications, serious damage may be done to a patient by virtue of an untoward drug **reaction**, and one must also be skilled in life-saving treatment of those reactions. Equally important is the possible delay of critical medical diagnosis and treatment by an intermediate nonmedical procedure for patients.

Nevada is fortunate to have many excellent optometrists and ophthalmologists working together to provide the finest quality eye care for our residents and visitors. Both professions work within the framework of their respective practices act, and at the present time, only ophthalmologists by virtue of their extensive medical education and training are authorized to use drugs in diagnosis, therapy and treatment of drug-related complications.

We believe there would be **significant danger** to the public if the Optometric Practices Act were modified to allow optometrists to expand the scope of their practice, when it is apparent that shools of optometry are not, and have not been, providing adequate training for such expanded usage of drugs.

Medical skills and training cannot be achieved by legislation. A.B. 580 intends through proposed statute change to effect what must be accomplished through educational and professional curriculum changes.

The Nevada State Medical Association urges a DO NOT PASS on A.B. 580.

Thank you.

NEIL SWISSMAN, M.D.
President

1425

NS:d

EXHIBIT M

Washoe County Medical Society

3660 BAKER LANE • RENO, NEVADA 89509 • (702) 825-0278

February 20, 1979

TO: Nevada State Legislators

FROM: Donald A. Molde, M.D., President

SUBJ: Proposed Changes in Optometric Law

By a unanimous vote, the Board of Directors of Washoe County Medical Society passed a resolution of support for the Nevada Opthalmological Society's position statement on the use of diagnostic drugs by optometrists.

Under the guise of expanding the health provider field, these practitioners, with limited licenses, would request of you the right to practice medicine without necessary training.

These non-medically trained individuals could well increase the cost of care through their lack of training and limited ability to make necessary diagnoses of diseases that may threaten an individual's eyesight or life.

We respectfully request that you reject any attempts to dilute the quality of health care in Nevada. With your help, your constituents will never be placed in the position of receiving medical eye care by non-medical practitioners.

DM:dar

AMA -

EXHIBIT M

ANNUAL CONVENTION, JUNE 27 - JULY 1, 1976

AMERICAN MEDICAL ASSOCIATION

9. RESOLUTION 76 — PRESCRIBING EYE MEDICATIONS

Resolution 76 asked that the AMA adopt the policy that only physicians licensed to practice medicine and surgery are qualified to prescribe or use eye medications and that they should be the primary entry point for eye care, and also asked that the AMA vigorously oppose any legislative or administrative attempt to give optometrists a license to prescribe or use medications or to serve as a primary entry point in the provision of eye services.

The House considered the following amended Substitute Resolution:

RESOLVED, That the American Medical Association reaffirm its policy that only physicians licensed to practice medicine and surgery in all its branches are qualified to prescribe or apply eye medications; and be it further

RESOLVED, That the American Medical Association continue to urge that state medical societies oppose any legislation or administrative attempt to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury; and be it further

RESOLVED, That the House of Delegates directs the attention of the constituent state societies to the position of the Association as stated in Resolution 169 (A-73).

SUBSTITUTE RESOLUTION 76 ADOPTED AS AMENDED

ANNUAL CONVENTION, JUNE 24 - 28, 1973

No. 169 REAFFIRMATION OF POSITION RELATIVE TO LEGISLATION AUTHORIZING DIAGNOSIS OF DISEASE

Introduced by Section on Ophthalmology
Harold F. Falls, M. D., Delegate
(Reference Committee B, page 412)

HOUSE ACTION: ADOPTED

RESOLVED, That the American Medical Association reaffirm that any legislation that would authorize optometrists to engage in the diagnosis or treatment of disease or injury, or the diagnosis of the absence of disease or injury, or to use drugs or medications in any form for any purpose is in conflict with the public interest, and that the Association urge constitutent societies unequivocally to oppose and to seek the defeat of any legislation that would extend the scope of optometry into these areas of the practice of medicine; and be it further

RESOLVED, That the constituent state societies be promptly informed by special communication of this action of the House, and that state societies where such legislation is now pending be officially informed without delay

BULLETIN

EXHIBIT M

May, 1978 of the Vol. 63 No. 5

AMERICAN COLLEGE OF SURGEONS

AMERICAN SURGEONS ABROAD:

Reports from Lebanon, Ethiopia, the USSR, and Vietnam — page 10

COLLEGE BRIEFS

College announces statement on use of drugs by optometrists

After receiving advice and counsel from the Board of Governors and the Advisory Council for Ophthalmic Surgery, the following statement has been approved by the Board of Regents of the American College of Surgeons:

"In the interest of maintaining a high standard of health care, the American College of Surgeons recommends that the diagnosis, management, and treatment of ocular diseases be carried out only by fully licensed practitioners of medicine.

"Further, the American College of Surgeons opposes legislation which permits the use of drugs for diagnosis and therapy by optometrists."

Prize-winning essay

The Georgia Chapter of the American College of Surgeons sponsored an essay competition for surgical residents from various surgical training programs within the state of Georgia in November of 1977. A $200 award was presented to Dr. Foad Nahai, resident in plastic and reconstructive surgery at Emory University. His paper was entitled "Free Transfer and Replantation of Composite Tissue by Microvascular Techniques."

EXHIBIT M

OPHTHALMOLOGY

TRANSACTIONS

AMERICAN ACADEMY of OPHTHALMOLOGY and OTOLARYNGOLOGY

Volume 81 NOVEMBER - DECEMBER 1976 Number 6

OP-993

WHEREAS, the AAOO has for 80 years directed its activities to the public interest, health, and welfare of the citizens of this country, and

WHEREAS, the AAOO is of the opinion that the use of prescription legend drugs by individuals not trained and licensed to practice medicine and surgery in all of its branches is detrimental to the health and welfare of the citizens of this country; therefore, be it

RESOLVED, that the AAOO is OPPOSED to all legislative authorization of individuals not licensed to practice medicine and surgery in all of its branches to use prescription legend drugs for either diagnostic or therapeutic purposes, or both.

O.P.E.N. C.O.P
ALL SCRAPBOOKS

The Association of University Professors of Ophthalmology, Inc.

EXHIBIT M

Sent to you as of [illegible]
PAUL R. [illegible]
1720 N. LEBANON ST.
LEBANON, INDIANA 46052

October 15, 1976

James L. McGraw, M.D.
Professor and Chairman
Department of Ophthalmology
College of Medicine
State University of New York
Upstate Medical Center
750 East Adams Street
Syracuse, New York 13210

Dear Dr. McGraw:

This letter is in response to your request for a statement of the position of the Association of University Professors of Ophthalmology, Inc. concerning the use of drugs by optometrists. The Trustees of the Association note that there are significant hazards in the use of drugs for diagnostic purposes and even greater hazards associated with the long term use of drugs for therapeutic purposes. The complications of the uses of ophthalmic drugs even as topical solutions, may occur in remote organ systems giving rise to serious symptoms and lead to medical diagnostic and therapeutic errors. The Trustees believe that only the complete medical education of a physician equips one to use drugs which will be absorbed systemically. The Trustees further believe that any non-physician using such drugs should be subject to the same civil and criminal penalties for their misuse as would be a physician.

Sincerely yours,

Jonathan D. Wirthschafter, M.D.
Secretary-Treasurer

JDW/ss

1430

AMERICAN ASSOCIATION OF OPHTHALMOLOGY
EXECUTIVE OFFICES • 1100 - 17th STREET, N.W., WASHINGTON, D.C. 20036 • TELEPHONE (202) 833-3447

EXHIBIT M

RESOLUTION

"WHEREAS, This Association is of the opinion that any legislative authority granted to independent non-medical practitioners to prescribe or to apply drugs is contrary to the public interest and a detriment to the health and welfare of the citizens of this country; be it

RESOLVED, That this Association is opposed to the legislative authorization of independent non-medical practitioners to prescribe or apply drugs for either diganostic or therapeutic purposes or both."

Adopted by the Board of Trustees of the American Association of Ophthalmology at its Annual Meeting held October 5, 1976 - Las Vegas, Nevada.

EXHIBIT M

THE OPHTHALMOLOGIST

PUBLISHED BY
AMERICAN ASSOCIATION OF OPHTHALMOLOGY

NOVEMBER/DECEMBER 1976

Resolution

"*Whereas*, This Association is of the opinion that any legislative authority granted to independent non-medical practitioners to prescribe or to apply drugs is contrary to the public interest and a detriment to the health and welfare of the citizens of this country; be it

Resolved, That this Association is opposed to the legislative authorization of independent non-medical practitioners to prescribe or apply drugs for either diagnostic or therapeutic purposes or both."

Resolution

"*Resolved*, That the Board of Trustees of the American Association of Ophthalmology go on record as supporting and encouraging those states which have begun actively public relations efforts; and be it further

Resolved, That the Board commends state public relations programs for assisting each of the various state programs and for demonstrating significant results in a short time, and feels that such efforts will compliment the National effort; and be it further

Resolved, That coordination and cooperation between the state programs be encouraged, and that the National program be directed to support state public relations programs where possible."

WSMA Adopts Important Resolution

The Washington State Medical Association recently adopted a resolution which affirms "that any legislation that would authorize optometrists to engage in the diagnosis or treatment of disease or injury or the diagnosis of the absence of disease or injury, or to perform any type of surgery, or to use drugs or medications in any form for any purpose, excepting when under the direct supervision of a licensed physician is in conflict with the public interest, and further, that the Washington State Medical Association shall actively oppose any legislation, the purpose of which is to direct or indirectly extend the right to practice medicine or surgery to optometrists, or in any way restrict or interfere with the proper practice of medicine and/or surgery by licensed physicians and surgeons." Similar resolutions have been adopted by other state medical societies.

Resolutions adopted by the A.M.A. House of Delegates urge that state medical societies oppose any legislation or administrative attempt to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury. Accordingly, more state medical societies have been taking an active role in opposing optometric drug proposals and it is expected that they will continue to do so when necessary.

1432

EXHIBIT M

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THE AD HOC BLACK LEADERS COMMITTEE JOINS NEW YORK STATE AFL-CIO, NEW YORK STATE CATHOLIC DAUGHTERS OF AMERICA, FEDERATION OF JEWISH WOMEN'S ORGANIZATIONS, NATIONAL COUNCIL OF JEWISH WOMEN NEW YORK STATE DIVISION, PROTESTANT CHURCHWOMEN, AND OTHER GROUPS IN OPPOSING PASSAGE OF ASSEMBLY BILL 10908 AND ITS COMPANION SENATE BILL 17838 WHICH WOULD PERMIT OPTOMETRISTS TO USE DRUGS IN EYES.

NEW YORK STATE CONSUMERS STRONGLY URGE POSTPONEMENT OF ANY ACTION UNTIL PUBLIC HEARINGS CAN BE HELD BASED ON SURVEY OF RESULTS IN STATES WHERE SUCH LAWS ARE IN EFFECT.

COPIES OF THIS MAILGRAM SENT TO NEWS MEDIA, TV, AND RADIO.

ROBERT H. WILSON, CHAIRMAN
AD HOC BLACK LEADERS COMMITTEE
(212) 724-7400

22:05 EST

MGMCOMP MGM

A copy of the above mailgram was sent to every member of the New York State Legislature.

3-20-78

EXHIBIT M

CHAPTER OF AARP

of the AMERICAN ASSOCIATION OF RETIRED PERSONS, Inc.

To the 1979 Nevada Legislature:

Chapter 308 of the American Association of Retired Persons recognizes that ophthalmologists are justified in opposing the use of eye medications by optometrists. We feel that eyes are too vital to leave to non-medical practitioners.

Bryan R. Metcalf

Bryan R. Metcalf,
Membership Chairman, A.A.R.P.

Assuming this legislation is enacted and you become certified to use "diagnostic" eye drugs, how would you handle these situations?

1. You (or the mother, upon your direction) instilled Atropine in a child's eyes. The mother calls you by phone 4 hours later to report the the child is flushed, feverish and restless. What would you advise her to do?

2. You instilled tetracaine or proparacaine anaesthetic into a patient's eyes in your office and patient suddenly turned pale, weak and slumped and slid from the chair. What would you do?

3. You wish to use a mydriatic or cycloplegic drug on a certain patient. Which drug, if any, would you choose or avoid if you knew that one or more of the following medical situations existed?

   peptic ulcer
   hypertension
   recent myocardial infarction
   pregnancy
   diabetes mellitus
   Stevens-Johnson syndrome
   cirrhosis of liver
   bronchial asthma
   premature ventricular contractions
   spastic colitis
   recent stroke
   cerebral palsey
   child with Riley-Day syndrome
   Graves disease
   history of epilepsy
   hypokalemia
   bradycardia
   auricular fibrillation

4. After dilating a patient's eyes, you instilled a miotic agent to counter-act the effect. Two hours later, the patient or family member phoned you to report that one of the eyes was red and aching. What would you advise them or do? And how would you alter your advice or management if both of you were in a far-out rural community?

13. Continuing Education Courses Directed Toward Care of the Aphakic Patient. Compiled by Division of Education and Manpower, American Optometric Association, 1976.

14. The United States Army's MOS Code 3340, "Optometry Officer", lists the duties of the optometrist:

> "Conducts examinations of eyes and, when appropriate, prescribes corrective treatment wirhout the use of medicine or surgery. Determines by means of ophthalmic instruments and optometric procedures, vision abnormalities which may be corrected or improved by contact or ophthalmic lenses, prisms or other ophthalmic devices; prescribes corrective lenses; refers patients for medical treatment or surgery when ocular manifestation of disease is detected; develops and monitors eye and vision protection programs; supervises optician technicians in fabricating and dispensing spectacles, manages optical service unit or lens laboratory; instructs and supervises subordinate personnel in optical and optometric procedures; engages in vision research; provides optometric consultant services; records optometric data on approved forms and records."

15. Chapman, W. Judd, O.D. "Optometry's Role in the Detection of Pathology". Military Med. 136:904, 1971.

16. Johnson, David E., O.D., M.P.H. "Optometric Triage in Military Screening." Optometry Weekly. 62 (36), September 9, 1971.

17. Myers, Kenneth J., O.D. "Veterans' Administration: We Train Health Professionals." J.Opt. Ed., V. 1 No. 2, Spring 1975.

18. Ibid.

19. Segadelli, Louis J. "Group Health Association - A Working HMO." Opt. Weekly. 65(5): 133-135. January 31, 1974.

20. Alexander, Raymond, M.B.A., M.S., Bellin, Lowell, M.D., M.P.H., Kavaler, Florence, M.D., M.P.H., and Rosenthal, Jesse, M.S., O.D. "The Participation of Optometrists in New York City's Medicaid Program." Pub. Health Reports, V. 84 No. 11, November 1969.

21. Haffner, Alden N., O.D., Ph.D., Jolley, Jerry L., O.D., M.P.H., and Soroka, Mort, M.P.A. "The Utilization of Optometric Services." J. Am. Opt. Assn., V.49 No. 10, October 1974.

22. The National Center for Health Statistics, Optometric Manpower: Characteristics of Optometric Practice, United States - 1968. DHEW Pub. No. (HRA) 74-1808, 1974.

Footnotes and Bibliography

1. Costs of Education in The Health Professions. Report of a Study. The Institute of Medicine, National Academy of Sciences. Washington, D.C., 1974.

2. Health Resources Statistics, 1974. National Center for Health Statistics, U.S. Department of Health Education, and Welfare. Rockville, Maryland, 1974.

3. The Health Careers Guidebook published jointly by the Department of Health, Education, and Welfare and the Department of Labor describes optometry as follows:

Referral

"An optometrist, Doctor of Optometry (O.D.), is educated and trained to examine eyes to detect vision problems. He may prescribe eyeglasses or contact lenses as needed, or he may recommend other optical treatment to preserve or to improve eyesight. If evidence of eye disease or injury is observed, he refers the patient to an opthalmologist for diagnosis or treatment. In addition, an optometrist may render service in any or all of the following areas:

"Contact Lenses: Recent years have seen greatly increased use of contact lenses. Much of the research and development has been done by optometrists. Some optometrists now devote their entire attention to prescribing and fitting contact lens. To others it has become an ever increasing part of their general practice.

"Children's Vision: Optometry is playing a leading role in discovering and solving children's vision problems, especially in the development and use of vision training and in orthoptics. Many optometrists specialize in children's vision; others serve as consultants to schools and school systems.

"Aids for the Partially Sighted: Many of the effective aids for the partially sighted have been developed by optometrists. Through their research, telescopic and microscopic lens systems have been improved to benefit many in the older age group; these aids have also helped thousands of children with seriously impaired vision.

"Vision Training: Vision training has long been recognized as an effective method of correcting some types of crossed eyes. It is also useful as a way to sharpen visual perception and to improve vision for reading. Some optometrists devote a large part of their time to this specialty; others include it as one of several services."

Blue SUBSTITUTE: STATE Board of Medical Examiners and STATE Board of Pharmacy

Exhibit P

PAGE 1 LINE 1

Former § 3041 was repealed by Stats.1976, c. 413, p. 1073, § 1.

Derivation: Former § 3041, added by Stats.1937, c. 422, p. 1391, amended by Stats.1949, c. 1161, p. 2082, § 1; Stats.1971, c. 1231, p. 2345, § 1.

Library References
Physicians and Surgeons ⇐6(5).
C.J.S. Physicians and Surgeons §§ 10, 23.

§ 3041.1 Use of topical pharmaceutical agents; rules and regulations; duration of section

(a) The State Board of Optometry with the advice and consent of the Division of Allied Health Professions of the Board of Medical Quality Assurance, to be provided within six months of the effective date of this section, shall adopt rules and regulations, including additional education qualifications, necessary to insure professional competence by those practitioners whose activities fall within the definition of the practice of optometry in subdivision (e) of Section 3041.

(b) Only those optometrists who have satisfactorily completed such courses and successfully passed an examination prepared and given by the State Board of Optometry, with the advice and consent of the Division of Allied Health Professions of the Board of Medical Quality Assurance, to be provided within six months of the effective date of this section, shall be permitted the use of such pharmaceutical agents as specified by subdivision ~~(e) of Section 3041~~.

This section shall remain in effect until December 31, 1979, and on such date is repealed.

(Added by Stats.1976, c. 418, p. 1074, § 3.)

Repeal

This section is repealed by force of its own terms on Dec. 31, 1979.

Library References
Physicians and Surgeons ⇐4.
C.J.S. Physicians and Surgeons § 12

§ 3041.2 Use of topical pharmaceutical agents; educational and examination requirements

The State Board of Optometry shall by regulation, with the advice and consent of the Division of Allied Health Professions of the Board of Medical Quality Assurance establish educational and examination requirements for licensure to insure the competence of optometrists to practice pursuant to ~~subdivision (b) of~~ Section 3041. Satisfactory completion of the educational and examination requirements shall be a condition for the issuance of an original certificate of registration under this chapter, on and after January 1, 1980. Only those optometrists who have successfully completed educational and examination requirements as determined by the State Board of Optometry with the advice and consent of the Division of Allied Health Professions of the Board of Medical Quality Assurance shall be permitted the use of pharmaceutical agents specified by ~~subdivision (a) of Section 3041~~.

(Added by Stats.1976, c. 418, p. 1074, § 4.)

Library References
Physicians and Surgeons ⇐4.
C.J.S. Physicians and Surgeons § 12.

§ 3042.5 Exceptions; students; instructors licensed in another state

1. In general

An optometry instructor who is licensed in another state, but not in California, as an optometrist and who has been granted an exemption under the Optometry Practice Act, may not maintain a private optometric practice, using the facilities of the school or college at which he is employed, inasmuch as the exemption granted by this section allows only practice conducted for educational purposes. 57 Ops.Atty.Gen. 629, 12-31-74.

§ 3044. Examination; application; fee; denial of application

Any person over the age of 18 years desiring to engage in the practice of optometry in this state may file an application for examination before the board.

The application shall be accompanied * * * by the fee required by this chapter and shall be filed with the board at least 30 days prior to the day of any meeting at which an examination is to be held.

Asterisks * * * indicate deletions by amendment

1438

EXHIBIT P

1978 Amendment. Substituted "Board of Registered Nursing" and "Board of Vocational Nurse and Psychiatric Technician Examiners" for "Board of Nurse Examiners" and "Board of Vocational Nurse Examiners."

ARTICLE 9. INACTIVE LICENSE [NEW]

Sec.
700. Legislative intent.
700. Unprofessional conduct: prescribing or administering of drugs or treatment: diagnostic procedures: diagnostic or treatment facilities [New].
701. Issuance.
702. Activities of holders.
703. Renewal: time: fees.
704. Restoration to active status.

Article 9 was added by Stats.1977, c. 410, p. —, § 1.

§ 700. Legislative intent

It is the intent of the Legislature to establish in this article an inactive category of health professionals' licensure. Such inactive licenses or certificates are intended to allow a person who has a license or certificate in one of the healing arts, but who is not actively engaged in the practice of his or her profession, to maintain licensure or certification in a nonpracticing status.
(Added by Stats.1977, c. 410, p. —, § 1, urgency, eff. Aug. 27, 1977.)

For another section of the same number, added by Stats.1977, c. 509, p. —, § 1, see § 700, post.

Library References
Physicians and Surgeons ⇐5(4), 11.2.
C.J.S. Physicians and Surgeons §§ 15, 17, 23.

§ 700. Unprofessional conduct; prescribing or administering of drugs or treatment; diagnostic procedures; diagnostic or treatment facilities

~~Repeated~~ acts of ~~clearly~~ excessive prescribing or administering of drugs or treatment, ~~repeated~~ acts of ~~clearly~~ excessive use of diagnostic procedures, or ~~repeated~~ acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the local community ~~of practice~~ is unprofessional conduct for a ~~physician and surgeon licensed pursuant to Chapter 5 commencing with Section 2000 of Division 2 or referred to in Section 3600, dentist, podiatrist, psychologist, physical therapist, chiropractor,~~ or optometrist.
(Added by Stats.1977, c. 509, p. —, § 1.)

For another section of the same number, added by Stats.1977, c. 410, p. —, § 1, see § 700, ante.

§ 701. Issuance

Each healing arts board referred to in this division shall issue, upon application and payment of the normal renewal fee, an inactive license or certificate to a current holder of an active license or certificate whose license or certificate is not suspended, revoked, or otherwise punitively restricted by that board.

As used in this article, "board" refers to any healing arts board, division, or examining committee which licenses or certifies health professionals.
(Added by Stats.1977, c. 410, p. —, § 1, urgency, eff. Aug. 27, 1977.)

Rules and regulations, see 16 Cal.Adm. Code 1310.

§ 702. Activities of holders

The holder of an inactive healing arts license or certificate issued pursuant to this article shall not engage in any activity for which an active license or certificate is required.
(Added by Stats.1977, c. 410, p. —, § 1, urgency, eff. Aug. 27, 1977.)

Asterisks * * * indicate deletions by amendment

EXHIBIT P

§ 3027. Executive officer and other necessary personnel; attorney general as counsel

Except as provided by Section 159.5, and in lieu of Section 3016, the board * * * shall employ an executive officer and other necessary assistance in the carrying out of the provisions of this chapter.

The executive officer shall perform such duties as are delegated by the board and shall be responsible to it for the accomplishment of such duties. The executive officer shall not be a member of the board. With the approval of the Director of Finance, the board shall fix the salary of the executive officer. The executive officer shall be entitled to traveling and other necessary expenses in the performance of his duties.

The Attorney General shall act as the legal counsel for the board and his services shall be a charge against it.
(Amended by Stats.1974, c. 1122, p. 2404, § 2.)

§ 3028. Repealed by Stats.1978, c. 1161, p. —, § 214

ARTICLE 3. ADMISSION TO PRACTICE

Sec.
3041. Optometry defined [New].
3041.1 Use of topical pharmaceutical agents: rules and regulations: duration of section [New].
3041.2 Use of topical pharmaceutical agents: educational and examination requirements [New].

§ 3040. Unlawful practice; prima facie evidence

It is unlawful for any person to engage in the practice of optometry or to display a sign or in any other way to advertise or hold himself out as an * * * optometrist without having first obtained a certificate of registration from the board under the provisions of this chapter or under the provisions of any former act relating to the practice of optometry.

In any prosecution for a violation of this section, the use of test cards, test lenses, or of trial frames is prima facie evidence of the practice of optometry.
(Amended by Stats.1978, c. 872, p. —, § 2.)

1978 Amendment. Deleted opticians from the application of this section.

§ 3041. Optometry defined

The practice of optometry is the doing of any or all of the following:

(a) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively.

(b) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition.

(c) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(d) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses which may be classified as drugs by any law of the United States or of this state.

(e) The use of topical pharmaceutical agents for the sole purpose of the examination of the human eye or eyes for any disease or pathological condition. The State Board of Optometry, with the advice and consent of the ~~Division of Allied~~ Health Professions of the Board of Medical Quality Assurance, to be provided within six months of the effective date of this section, shall designate the specific topical pharmaceutical agents, known generically as mydriatics, cycloplegics, and topical anesthetics, to be used.
(Added by Stats.1976, c. 418, p. 1073, § 2.)

Underline indicates changes or additions by amendment

P 3 L 24

Exhibit Q

AFFILIATED WITH
THE AMERICAN OPTOMETRIC ASSOCIATION

AFFILIATED WITH
INTERNATIONAL BOARD OF BOARDS

NEVADA STATE BOARD OF OPTOMETRY

TOPICAL PHARMACEUTICAL AGENTS MEANS THE FOLLOWING TYPE DRUGS AND MAXIUM CONCENTRATION THAT MAY BE USED. THE BOARD WILL ADOPT AS AN AMENDMENT TO THE BOARD RULES AND REGULATIONS THIS LIST OF TOPICAL PHARMACEUTICAL AGENTS, WHICH WILL BECOME EFFECTIVE UPON THE DATE OF APPROVAL OF AB 580.

TYPES OF DRUGS:	MAXIUM CONCENTRATION THAT MAY BE USED.
(1) Mydriatics	
(a) Phenylephrine Hydrochloride:	2.5%
(b) Hydroxyamphetamine Hydrobromide:	1%
(2) Cycloplegics	
(a) Tropicamide:	1%
(b) Cyclopentolate:	1%
(c) Homatropine Hydrobromide:	5%
(d) Atropine Sulfate:	0.5%
(3) Topical Anesthetics	
(a) Proparacaine Hydrochloride:	0.5%
(b) Benoxinate Hydrochloride:	0.4%
(c) Piperocaine Hydrochloride:	2%
(4) Miotics	
(a) Pilocarpine:	1%
(b) Pilocarpine: (Emergency Only)	3%

Robert T. Myers O.D.
President