House
Legislative
Analysis
Section

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OPTOMETRIC SCOPE OF PRACTICE

House Bill 4330 as introduced
House Bill 4331 (Substitute H-2)
First Analysis (5-13-93)

Sponsor: Rep. Michael J. Bennane
Committee: Public Health

THE APPARENT PROBLEM:

The Public Health Code allows optometrists to use only two specific drugs: Proparacaine HCL 0.5 percent and Tropicamide in strength not greater than one percent. Both of these drugs are topically applied (that is, applied to the surface) to the eye and both are used for diagnosis only. Proparacaine is an anesthetic used in detecting glaucoma, while Tropicamide is a commercially prepared pupil-dilating drug used in evaluating the structure and function of the eye. Optometrists are prohibited from using any diagnostic drugs other than the two specified in the health code and are prohibited from using any therapeutic drugs (that is, drugs used to treat disease) at all.

Optometrists, non-physicians who are best known for examining eyes to see if glasses are needed, say that allowing them limited use of certain therapeutic drugs would greatly benefit the public without any additional risks. Ophthalmologists, physicians who specialize in eye surgery, remain opposed to optometrists using drugs as part of optometric practice, arguing that optometrists are not adequately trained to deal with adverse reactions that can arise when prescription drugs are used.

As happened in 1984, in the case of legislation that authorized optometrists to use diagnostic drugs, and as is common in "scope of practice" disputes between licensed health professionals, the legislature has been called upon to referee.

THE CONTENT OF THE BILLS:

The bills would allow certain optometrists to administer and prescribe certain drugs and would set certification fees for qualified optometrists to administer these drugs.

House Bill 4330 would amend the State License Fee Act (MCL 338.2261) to delete the existing reference to "topical ocular" diagnostic drugs and instead to set up two optometric drug certification categories: one for the administration of diagnostic pharmaceutical agents (DPAs) and one for the administration and prescription of therapeutic pharmaceutical agents (TPAs). The certification application fee would remain $20, while the certification fees for both DPAs and TPAs would be $55 (currently, the DPA certification fee is $55).

House Bill 4331 would amend the Public Health Code (MCL 333.17401 et al.) to allow properly certified optometrists to use certain therapeutic drugs (and to allow pharmacists to dispense these drugs to such optometrists) specified by a newly created "optometric formulary panel." Properly certified optometrists also would be allowed to use, in addition to the two diagnostic drugs now specified in the health code, additional diagnostic drugs as specified by the optometric formulary panel. Finally, in addition to expanding the optometric scope of practice to include the prescription and administration of certain therapeutic drugs, the bill would add the diagnosis of disease (in addition to the existing ability to determine defects or abnormal conditions that can be corrected by lenses) to the definition of optometric scope of practice.

Scope of practice. Under existing law, the practice of optometry does not include the diagnosis of disease or the prescription and administration of controlled substances, with the exception of two diagnostic drugs ("diagnostic pharmaceutical agents," or "DPAs") specified in the health code. Optometric practice basically is limited to the examination of the human eye for "defects" and "abnormal conditions" and to the prescription of glasses ("lenses, prisms, or mechanical devices," including contact lenses) to correct any such defects or abnormalities.

The health code does allow optometrists to use two diagnostic drugs during eye examinations (one an anesthetic used in detecting glaucoma, the other a pupil-dilating drug), but explicitly prohibits optometrists from prescribing or administering any other prescription drugs. If an optometrist, in the course of an eye examination, "determines" that the patient may have an eye disease, the optometrist is required to advise the patient to see a physician and is prohibited from attempting to treat the suspected disease. The code also explicitly prohibits optometrists from accepting third-party (that is, insurance) payment for using the drugs currently allowed them.

The bill would redefine the practice of optometry. It would restrict optometrists to treating "localized" visual defects, abnormal conditions, and diseases of the front of the eye ("the anterior segment") and "the ocular adnexa" (that is, the structures surrounding the eyeball, including the eyelids, eyebrows, tear drainage system, eyeball walls, and eyeball contents). It would specifically exclude the treatment of diseases or abnormal conditions involving the back of the eye ("the posterior segment"), of nonlocalized or systemic diseases or conditions, and of postoperative care. For the first time, however, the bill would allow optometrists to diagnose and treat the specified localized problems; to use both "diagnostic pharmaceutical agents" (DPAs) and "therapeutic pharmaceutical agents" (TPAs); and to prescribe and use orthoptics, visual therapy, DPAs, TPAs, prosthetic devices, "and other noninvasive procedures," in addition to lenses and prisms.

Diagnostic pharmaceutical agents (DPAs) and therapeutic pharmaceutical agents (TPAs). "Diagnostic pharmaceutical agents" would continue to include the two DPAs currently allowed in the Public Health Code, while also including any others designated by rule by the optometric formulary panel. "Therapeutic pharmaceutical agents" would mean certain controlled substances (orally administered schedule 3, 4, or 5 analgesic agents) or certain prescription drugs (drugs allowed to be dispensed only under a prescription and with a federal warning label that federal law prohibited dispensing the drug without a prescription) also designated by rule by the optometric formulary panel.

The optometric formulary panel. The bill would create a seven-member optometric formulary panel, in the Department of Licensing and Regulation. (Note: the department was abolished on September 1, 1991, by executive order 1991-9 and its functions assumed by the Department of Commerce). The panel would consist of the director (or his or her designee), two optometrists appointed by the Board of Optometry, two pharmacists appointed by the Board of Pharmacy, and two ophthalmologists (i.e. medical or osteopathic physician specialists), one appointed by the Board of Medicine and one by the Board of Osteopathic Medicine and Surgery. Appointed members would serve for four years and could not serve for more than two full terms and one partial term. The director would chair the panel, which would have to meet all of the general requirements for health profession boards, and would be an ex officio voting member.

The panel would promulgate rules designating which diagnostic or therapeutic drugs optometrists could use, and the conditions under which the drugs could be administered and prescribed. In promulgating these rules, the panel would have to consider, at a minimum, the clinical training and education of optometrists, the potential need for referral to physicians, and the need for timely treatment. The panel also would be required to submit the rules regarding therapeutic drugs for public hearing under the Administrative Procedures Act within 90 days after the bill took effect.

Certification to use diagnostic and therapeutic drugs. The bill would require optometrists who were certified to administer diagnostic or therapeutic drugs to comply with rules promulgated by the optometric formulary panel, and would prohibit them from administering any drugs that the panel had not designated as diagnostic or therapeutic. (Properly certified optometrists still would be allowed to use the two diagnostic drugs currently allowed them under the code.) Licensed optometrists would be explicitly prohibited from administering or prescribing controlled substances or prescription drugs that had not been designated by rule as therapeutic pharmaceutical agents.

Optometrists licensed after the bill took effect and who intended to administer DPAs or to administer and prescribe TPAs would have to be certified when they were initially licensed to practice optometry.

After the effective date of the rules promulgated by the optometric formulary panel, licensed

optometrists could become certified to administer and prescribe therapeutic drugs if they:

* were certified by the Board of Optometry to administer diagnostic drugs;
* successfully completed certain academic work in courses on the didactic and clinical uses of therapeutic drugs or passed a board-approved examination on the treatment and management of eye disease;
* paid the appropriate fee; and
* complied with rules promulgated by the optometric formulary panel.

Pharmacists. The bill would authorize pharmacists to dispense DPAs ("diagnostic pharmaceutical agents") and TPAs ("therapeutic pharmaceutical agents") to qualified optometrists, and to dispense prescriptions for TPAs issued by qualified optometrists.

Repeal. The bill would repeal the section of the health code that prohibits optometrists from accepting third-party payment for using diagnostic drugs.

Effective date. The bill would take effect one year after it was enacted into law.

Tie-bar. House Bill 4330 is tie-barred to House Bill 4331, and House Bill 4331 is tie-barred to a set of bills (House Bills 4569 through 4573) that would allow certain third-party reimbursement for optometric and chiropractic services.

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

The bill is an attempt to work out a compromise between optometrists, non-physicians who favor expanding their scope of practice to include the prescription of therapeutic drugs, and ophthalmologists, physicians who oppose what they see as further encroachments on medical practice by non-physicians. The bill would allow some specially qualified optometrists to use certain diagnostic and therapeutic drugs that a specially created panel of experts in drugs and eye care (pharmacists, optometrists, and ophthalmologists) approved for use by optometrists. The list of drugs would have to go through a further, public hearing process under the Administrative Procedures Act and be approved by the legislature's Joint Committee on Administrative Rules (JCAR). Optometrists would continue to have to refer patients to ophthalmologists whenever the optometrist detected signs of other than localized eye disease. The bill also would recognize optometrists' right to diagnose disease (traditionally a function only of the medical profession)--a right already existing in current law and practice, which allows optometrists to "ascertain departures from the normal" and to "determine" that patients have "signs and symptoms which may be evidence of disease."

For:

Optometrist proponents of the bill point to studies suggesting that optometric care is more accessible to health care consumers (in terms of shorter waiting times for appointments, more evening and weekend appointments, and greater geographic distribution of optometrists, who, for example, tend to be proportionally more represented in rural areas than ophthalmologists) and less expensive to both consumers and third-party payers than is primary eye care provided by ophthalmologists. Optometrists emphasize their cost savings to consumers and health insurers based on optometrists' generally lower office overhead costs (including lower malpractice insurance rates than ophthalmologists by more than a factor of ten) and lower educational costs. Optometrists also argue that allowing them to use therapeutic pharmaceutical agents ("TPAs") can further lower health care costs by reducing second provider fees (currently, optometrists must refer patients with even minor eye diseases, such as "red eye," to physicians) and by saving patients the costs of additional travel time and lost work time in order to see these "second providers." Optometrists point out that optometrists in the military, the federal Indian Health Service, the federal Veterans' Administration, and 26 other states already are allowed to use therapeutic drugs and non-invasive procedures to treat common eye diseases, and argue that Michigan should allow this also. Finally, they point out that the dire predictions of public harm that were used to argue against the 1984 legislation that allowed optometrists to use "diagnostic pharmaceutical agents" ("DPAs") simply failed to come true. In fact, there have been no complaints to the Michigan Board of Examiners in Optometry concerning optometrists' misuse or abuse of these diagnostic drugs, and there is evidence from other states that allow optometrists to administer

therapeutic drugs that there has been no increase either in public complaints or in malpractice insurance rates.

For:

Modern optometric education and clinical training provide the necessary background to allow optometrists to use therapeutic drugs safely and effectively, and the bill would further ensure that all optometrists who used such drugs complete a certification process to guarantee competency (the bill does not include so-called "grandfathering" provisions). While it is understandable that physicians would oppose further inroads by limited license practitioners on physicians' once virtual monopoly on primary care, the fact remains that other limited license practitioners (including dentists and podiatrists) have increased their scope of practice as their education and training has improved. As one study (by an M.D. with a master's degree in public health) notes, "Laws regulating the practice of optometry were written as we entered this century. While they subsequently served as a useful beginning point, they are no longer up-to-date with respect to the education and clinical training of the modern-day optometrist. In a pattern similar to the evolution of medicine, the apprentice optometrist of the 1890s has become a university graduate with a doctorate in a distinct health care discipline. Advances in education through basic and applied research have placed the graduate optometrist alongside the physician and dentist as the third largest independent health care discipline." This same study points out that decades of experience with dentists and podiatrists prescribing drugs (with potentially general physiological impact on the patient's body) without imminent or remote supervision by physicians has not resulted in a single state repealing its laws granting this privilege due to negative outcome. As the author of the study says, "Accordingly, today's legislator is less likely from now on to accept uncritically the claim by physicians that prudence demands that physicians alone should be allowed to write prescriptions."

Against:

Ophthalmologists argue that optometrists do not have the training and education to diagnose and treat eye diseases, nor to treat adverse drugs reactions. They further deny that the economic benefits to the public and to health insurers will be as great as the optometrists claim, pointing out that historically an increase in the number of primary eye care practitioners drives up health costs (partly, for example, because the federal government pays most professions the same fee for the same services), rather than decreasing them. With regard to the issue of access to care, the Department of Social Services (DSS) said in 1991 that were 450 ophthalmologists (virtually all of the ophthalmologists in the state) and 574 active optometrists (out of approximately 1,400 in the state) accepting Medicaid patients. The department's Medicaid staff reports that clients generally do not have problems with access to vision care providers and that there is no significant problem with unmet needs for vision treatment. Medicaid payment levels are the same for both types of providers, and the department assumes that the bill would not result in an increase in Medicaid utilization since clients seem to be receiving needed treatment.

Ophthalmologists also argue that the eye cannot be treated as an organ isolated from the rest of the body, and that diagnosis and treatment of eye disease should be done only by those who are trained in medicine dealing with the whole person. For example, not only can certain systemic diseases, such as diabetes and tuberculosis, be detected by looking at the eye (provided that the examiner has the requisite medical training), but medications applied to the eye can affect the whole body. While optometrists do have some classroom study in pharmacology, their clinical training and experience nowhere matches that of even general physicians, much less ophthalmologists. As one ophthalmologist put it, optometrists are trying to enter the practice of medicine through legislation rather than medical school.

Response:

While it is indeed true that the eye is an integral part of the body, so, too, are one's feet and teeth and gums. Podiatrists and dentists have been, like optometrists, categorized as limited license practitioners, yet both professions are allowed to write prescriptions for drugs with the potential to affect the entire body. The fact is, as the education and training of health professions deemed "auxiliary" to that of medicine have grown and changed over the years, there has been a continuous expansion of scope of practice and licensure of the "limited license" health professionals. The once exclusive domain of medicine has been successfully challenged, both through legislation and by incremental changes in the traditional practice of the "auxiliary" health professions. Partly, this has

stemmed from the public recognition that it is in the public interest to utilize each health professional in a way that maximizes the highest levels of that professional's skills and that levels of health care should be assigned to the most appropriate providers (that is, primary care to providers trained in primary care, secondary and tertiary care to providers trained in these levels of care). But there also has been a growing recognition that health competition among qualified health professionals will benefit both consumers and third-party payers. The bottom line is that optometrists do not want to practice medicine; but they do want to practice primary eye care at a level commensurate with their education and training.

Against:

The bill, by requiring a public hearing process under the Administrative Procedures Act (and approval by the Joint Committee on Administrative Rules) for the rules determining which drugs optometrists could use, would set up an unnecessarily clumsy process for approving drugs for optometric use. In addition, the JCAR wouldn't have the medical expertise to decide on the appropriateness of the drugs involved, thereby imposing an inappropriate task on the committee. Finally, by adding a new panel, the "optometric formulary panel," to the already existing Board of Examiners in Optometry, the bill would dilute the authority of the existing board and unnecessarily divide accountability for decision making among the panel, the board, and the JCAR.

POSITIONS:

The Michigan Optometric Association supports the bills. (5-12-93)

Representatives of the following organizations testified in opposition to the bills (5-5-93):

The Michigan Ophthalmological Society
The Economic Alliance for Michigan
The Michigan Farm Bureau
The Michigan State AFL-CIO
The Michigan Education Association
The Service Employees International Union