House Legislative Analysis Section
Romney Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

ANTI-GLAUCOMA DRUGS: OPTOMETRISTS

Senate Bill 139 as passed by the Senate
Sponsor: Sen. Joanne G. Emmons

Senate Committee: Health Policy and Senior Citizens
House Committee: Health Policy

First Analysis (10-22-97)

THE APPARENT PROBLEM:

Public Act 384 of 1994 amended the Public Health Code to allow properly certified optometrists to prescribe and administer topical therapeutic drugs for the treatment of conditions such as "pink eye", certain corneal abrasions, and other common eye disorders that affect the front part of the eye. However, an optometrist is required to refer patients to an ophthalmologist whenever the optometrist detects signs of other than localized eye disease. Reportedly, some optometrists felt that Public Act 384 authorized them to treat certain forms of glaucoma, a potentially serious disease of the optic nerve caused by a fluid buildup in the eye which can lead to blindness. In response to a legislative inquiry, the attorney general issued Opinion No. 6846 in May of 1995. In his opinion, the attorney general concluded that the language in Public Act 384 restricted optometrists to using topical therapeutic pharmaceuticals that treated the anterior, or front part, of the eye, and that "since anti-glaucoma topically administered drugs relieve defects that extend beyond the anterior segment of the eye . . . the Public Health Code does not authorize optometrists to treat glaucoma."

According to information supplied by the Michigan Optometric Association, 39 states authorize optometrists to treat glaucoma, many with both topical and oral pharmaceuticals. Some states have authorized optometrists to treat glaucoma for almost 20 years, which many believe demonstrates that optometric treatment of glaucoma can be performed safely and effectively. Further, the association reports that based on a review of the underwriting results for three major insurance carriers for a period of seven years, and that "since claims and premiums are so closely related to incidents of harm and injury to patients, there is no evidence that there is a correlation between the treatment of glaucoma by optometrists and malpractice claims."

However, there has been an ongoing debate as to the advisability of further expanding the scope of practice of optometrists to include treating a disease as potentially serious as glaucoma by other than a licensed physician. Ophthalmologists maintain that the educational requirements for a license in optometry does not provide the knowledge and experience necessary to properly diagnose or treat the disease. Glaucoma often is a symptom of a greater systemic illness or disease such as diabetes, lupus, tuberculosis, or AIDS. A particular form of glaucoma, angle-closure glaucoma, is particularly serious and is treated as a medical emergency requiring surgical intervention. Ophthalmologists, unlike optometrists, must complete a three-year residency in ophthalmology in addition to attending medical school. In addition, ophthalmologists, who are physicians, state that they also have more extensive training in understanding drug reactions and interactions. Ophthalmologists maintain that they are therefore better suited to treat a disease that not only affects the whole eye, but that affects and is affected by the whole body.

Earlier this year, at the urging of legislators, representatives of the Michigan Optometric Association and the Michigan Ophthalmological Society met on several occasions to resolve the issue of whether it was appropriate for certified optometrists to treat glaucoma. A compromise was reached whereby optometrists could prescribe and administer anti-glaucoma topical drugs, but only in a co-management mode with consultation between the optometrist and an ophthalmologist. However, the compromise language was rejected by the general membership of the Michigan Ophthalmological Society at their annual meeting in late summer. As has happened several times in past years in "scope of practice" disputes between licensed health professionals, legislation has been introduced to settle the matter.

THE CONTENT OF THE BILL:

The bill would amend Part 174 of the Public Health Code, which governs the practice of optometry, to allow an optometrist to use a topically administered anti-glaucoma drug; and to require an optometrist to consult with an ophthalmologist when glaucoma was suspected in a patient's diagnosis, or with a physician when an optometrist diagnosed that a patient had acute glaucoma.

Currently, under Part 174, an optometrist may administer and prescribe therapeutic pharmaceutical agents in the course of his or her practice, if he or she has fulfilled certain requirements specified in Part 174 and been certified by the Board of Optometry as qualified to administer and prescribe therapeutic pharmaceutical agents. "Therapeutic pharmaceutical agent" means a topically administered prescription drug or other topically administered drug used to treat a defect or abnormal condition, or the effects of a defect or abnormal condition, of the anterior (front) segment of the human eye. The bill provides that a therapeutic pharmaceutical agent also would include a topically administered anti-glaucoma drug.

Further, under current law, if an optometrist determines that a patient shows signs or symptoms that may be evidence of disease that the optometrist is not authorized to treat, the optometrist must promptly advise the patient to seek evaluation by an appropriate physician, and not attempt to treat the condition. However, in the case of glaucoma, the bill specifies that when a diagnosis of glaucoma was suspected, the optometrist would have to consult an ophthalmologist for a co-management consultation in order to agree mutually on the diagnosis and initial treatment plan. If the results of treatment did not meet or exceed the treatment target goals within a time frame currently accepted as the medical standard of care in the treatment and management of glaucoma, the optometrist would have to consult further with an ophthalmologist regarding further diagnosis and possible treatment.

If an optometrist diagnosed that a patient had acute glaucoma, the optometrist would have to consult a physician for further diagnosis and possible treatment as soon as possible.

MCL 333.1701 and 333.17432

BACKGROUND INFORMATION:

Under current law, an order to administer either of the two allowable diagnostic drugs (Proparacaine -- an anesthetic used in detecting glaucoma, and Tropicamide -- a commercially prepared pupil-dilating drug used in evaluating the structure and function of the eye), optometrists must be certified by the Board of Optometry and meet certain specified qualifications. Before the board may certify an optometrist to use diagnostic drugs, the optometrist must have done the following: (1) Completed 60 classroom hours of board-approved study in general and clinical pharmacology as it relates to optometry from a fully accredited school or college of optometry. At least 30 of these hours must be in "ocular pharmacology" and must emphasize the systemic effects of and reactions to diagnostic drugs, including the emergency management and referral of any possible adverse reactions to the drugs; (2) passed a board-approved examination on general and ocular pharmacology, with a particular emphasis on the use of diagnostic drugs (including emergency management and referral of possible adverse reactions); (3) successfully completed a course in cardiopulmonary resuscitation offered or approved by the Red Cross, the American Heart Association, an accredited hospital, or a comparable organization or institution; and (4) established a board-approved emergency plan for the management and appropriate medical referral of patients who experience adverse drug reactions. Emergency referral plans must, further, require optometrists to do at least four things: (1) Refer patients who notify the optometrist of adverse drugs reactions to "appropriate" medical specialists or facilities; (2) routinely advise each patient to immediately contact the optometrist if the patient experiences an adverse drug reaction; (3) record adverse drug reactions in the patient's permanent record, along with the date and time of any referrals; and (4) list the names of at least three physicians, clinics, or hospitals to whom the optometrist will refer patients with adverse drug reactions, at least one of which must be skilled or specialize in the diagnosis and treatment of eye diseases.

Public Act 384 of 1994 further expanded the scope of practice of optometrists by allowing optometrists to administer and prescribe therapeutic drugs if they were certified by their board to do so, and the board could certify optometrists to administer and prescribe therapeutic drugs if the optometrist did the following: (1) met the certification requirements to administer diagnostic drugs; (2) had successfully completed a certain amount of study in the didactic and clinical use of therapeutic drugs from a school or college of optometry that was recognized by the board as fully accredited; and (3) established a management plan that met the requirements of the emergency plan for diagnostic drug reactions. The management plan would apply to patients who either (a) had an eye condition or disease that might "be related to a non-localized or systemic condition or disease" or to an adverse drug reaction or (b) didn't "demonstrate adequate

clinical progress as a result of treatment." (For further information, see the House Legislative Analysis Section's analysis of House Bill 4331, Public Act 384 of 1994, dated 1-3-95.)

In a related matter, the Public Health Code, the Insurance Code, the Prudent Purchaser Act, and the Nonprofit Health Care Corporation Act were all amended in the same year to exempt various insurance providers from mandatory coverage or reimbursement for a practice of optometric service that was not included in the Public Health Code's definition of "practice of optometry" as of May 20, 1992. (For further information, see the House Legislative Analysis Section's analysis of House Bills 4569-4573 dated 1-5-95.)

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the bill would have no state or local fiscal impact. (10-20-97)

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 to treat glaucoma, and ophthalmologists, physicians who oppose what they see as further encroachments on medical practice by non-physicians. The fact that at least 39 states allow optometrists to treat glaucoma, some for as long as 20 years, offers evidence that optometrical treatment of glaucoma can be done safely and effectively, especially the treatment of primary glaucoma, where only the eye is involved and the condition is not secondary to a systemic illness. The bill would require that any diagnosis and treatment be rendered in a co-management mode in consultation with an ophthalmologist. Historically, optometrists and ophthalmologists have worked very well together, and the bill gives flexibility for the two health professionals to form a working relationship with each other in a manner that they will be comfortable with. For acute glaucoma, which is deemed a medical emergency, an optometrist would have to contact a physician, such as at the local emergency room, for consultation for diagnosis and treatment.

Though optometrists have not completed medical training to the extent of ophthalmologists, an optometrist does complete a four-year program, and many feel that modern optometric education and clinical training do provide the necessary background to allow optometrists to use therapeutic drugs safely and effectively. The law already ensures that all optometrists who use such drugs must complete a certification process to guarantee competency. 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.

For:

Optometrists maintain that the bill would save health care dollars by permitting patients to seek treatment for glaucoma by optometrists, whose practices often are more open to new patients and who charge lower fees, than by the current practice where an optometrist must advise a patient to see an ophthalmologist when glaucoma is suspected. Instead of two office visits, a patient need only be seen and treated in one office. Since optometrists typically have shorter waiting lists and are often more plentiful in an area than ophthalmologists, patients may find it easier to come in for check-ups and treatment.

Response:

Glaucoma is an incurable disease. It requires lifetime treatment, which may include surgery. An optometrist may diagnosis glaucoma after a consultation with an ophthalmologist, but the patient would still have to make repeated visits to the optometrist for treatment and monitoring. If the patient were not responding according to medical standards, the patient would most likely have to be referred to an ophthalmologist anyway. In addition, if the patient needed more advanced treatment, such as laser treatment or other forms of surgery, he or she would have to be seen by an ophthalmologist. Therefore, it is likely that the bill would only save one visit initially, for then a person would still have to see one or the other for regularly scheduled appointments. Further, ophthalmologists maintain that having patients see only an optometrist for treatment could result in delays of certain treatments such as surgery that could have prevented further vision loss if done in a more timely fashion.

Against:

The bill's requirement for a co-management consultation mode between optometrists and ophthalmologists raises a number of questions as to increased cost and insurance reimbursements. Most likely, the ophthalmologist would not examine the patient himself or herself, but would rely on a description by the optometrist. Yet, the bill is asking for ophthalmologists to assume some medical liability for the consultation. It is unrealistic for a doctor to assume medical liability without financial remuneration of some amount. This in turn poses a problem for insurance providers. Many plans cover such treatment for services provided by ophthalmologists, but not by optometrists. In fact, current law provides that insurances providers do not have to cover services by optometrists that were not contained in the pre-1992 definition of scope of practice for optometrists in the Public Health Code. But, the bill may be interpreted to force providers to now cover such services because of the involvement, no matter how incidental, of an ophthalmologist. Committee testimony revealed that the consultation required by the bill most likely would take the shape of a phone call, or even a fax. Patients would not be referred, as now, to an ophthalmologist for a direct examination. Reportedly, in the case of Medicare patients, it may be illegal for ophthalmologists to do a consultation over the phone, as Medicare contains strict criteria that require ophthalmologists to do a hands-on examination. Indeed, few if any ophthalmologists may be willing to concur on a diagnosis and treatment plan without actually examining a patient, especially if in so doing, he or she may be liable for a malpractice suit. Therefore, the optometrists main claim that they can provide primary glaucoma treatment in a more cost-effective setting may in actuality contain little, if any, costs savings.

Against:

The bill begins to set some potentially dangerous precedents, such as statutory authority to diagnose a patient sight unseen. Where it is not uncommon for one physician to call another to discuss a case over the phone, this is seen as one physician merely giving advice or an opinion to another doctor, not rendering a diagnosis without seeing a patient face to face. And, though telemedicine has brought advances whereby x-rays and MRIs and other test results are able to be sent by electronic transmissions to specialists for diagnoses, such diagnostic tests as these are at least an accurate representation of the patient's condition. The specialist is then using his or her expertise to read a patient's test result and draw a conclusion. In the case of a phone consultation, an ophthalmologist would be statutorily authorized to make a diagnosis based on another person's (and one who did not have the same level of education and clinical experience) description of a patient's eye along with the examination results. Perhaps this is a

practice that should not be legislatively sanctioned at all, or at least not until technological advances would make the diagnosis and treatment of glaucoma somewhat more of an exact science.

POSITIONS:

The Michigan Optometric Association supports the bill. (10-21-97)

The Michigan State Medical Society opposes the bill. (10-21-97)

The Michigan Osteopathic Association opposes the bill. (10-20-97)

A representative of the Economic Alliance for Michigan testified in opposition to the bill. (10-21-97)

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.