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1971 - 2011: Forty-Year History of Scope Expansion into Medical Eye Care

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Over 110 years ago, on April 13, 1901, Minnesota Senate Bill 188 was signed into law establishing the first optometry practice Act. That first scope of practice was defined as:

An act to regulate the practice of optometry.

Be it enacted by the Legislature of the State of Minnesota:

Section I. The practice of optometry is defined as follows, namely: *The employment of subjective and objective mechanical means to determine the accommodative and refractive states of the eye and the scope of its functions in general."* [2]

Over the next 23 years a law to license optometrists and define the scope of services optometrists could legally provide was enacted in every state and the District of Columbia, with the last practice Act enacted on May 28, 1924 in the District of Columbia. In fact, four optometry practice Acts were approved while the jurisdiction was still a territory. These territorial enactments included: New Mexico, enacted March 16, 1905; Arizona, enacted March 14, 1907; Hawaii, enacted April 30, 1917; and Alaska, enacted May 2, 1917.

Beginning with the passage of a law in Rhode Island in 1971 authorizing the use of diagnostic drugs, to the enactment of a law in Kentucky in 2011 authorizing the use of surgery and therapeutic lasers, the scope of the practice of optometry has been expanded into medical eye care ***well over 180*** times legislatively during the last 40 years in the various U.S. jurisdictions. This historic chapter in the evolution of optometry saw a sweeping transformation of the profession from the expert, but "drugless" refractionists of the early 1900's, to detecting and referring eye disease at mid-Century, to today's largest eye and vision care profession,[3,4] providing patients access to safe and effective vision and medical eye care from their local doctor of optometry.

Due to political compromise some of the scope of practice expansion or amplification laws into medical eye care contained a sunset provision that, if not extended or repealed, had the potential to undo a legislative victory. [5] None of the sunset provisions that were enacted survived to accomplish the obvious goal of the opposition; to revert to an earlier statutorily defined scope of practice. So it is important to note that, in addition to the well over 180 enactments, no optometric scope of practice expansion or amplification law has ever been diminished or repealed at a later date by a state legislature.

The legislative steps to expand the authorized scope of practice over the course of this dynamic 40 year period in the evolution of the profession, while sometimes breathtaking in their achievements, were more oftentimes small and incremental, as curriculum and legislative successes each grew over time. Optometrists in every state and the District of Columbia educated legislators regarding the training of modern optometrists as they worked to pass laws expanding the scope of practice commensurate with the expanded curriculum, and in order to better meet the medical eye care needs of their patients.

Components of Scope of Practice Expansion

There have been four basic interconnected legislative components related to scope of practice expansion into medical eye care over the past 40 years. Each of these essential elements of expansion was achieved by the various states at their own pace. In fact, there are many areas where further amplification efforts remain to be enacted in order for the states to achieve more uniformity from one to the other regarding prescriptive authority and the ability to perform non-surgical and surgical primary care procedures.

The Four Components:

1 — Use of "Diagnostic Pharmaceutical Agents" or "DPAs." This terminology, and the resultant acronym, was coined by the profession to easily explain to lay non-medical legislators, legislation seeking to authorize the use of diagnostic drugs within the practice to facilitate the examination. The ability to use anesthetic, dilation, and other topical drugs in the office was a significant first step in the transformation of optometry into the profession it is today.

2 — "Diagnosis" of Disease. Over time, the early optometry practice Acts generally had been amended to authorize optometrists to "detect," "recognize," or "ascertain" diseases or conditions of the eye with a requirement that the optometrist then refer the patient to a medical physician for confirmation of diagnosis and commencement of treatment. This form of legislation sought to specifically establish the legal responsibility of optometrists to "diagnose" diseases or conditions of the eye and vision system. This effort was tied to diagnostic, or more frequently, therapeutic prescriptive authority expansion efforts.

3 — Prescription of "Therapeutic Pharmaceutical Agents" or "TPAs." As with DPAs, the "TPA" terminology and acronym were also coined by the profession to easily explain to lay legislators, legislation seeking to authorize the prescription of medication to treat many of the diseases or conditions of the eye and related structures that optometrists were educated and trained to diagnose.

4 — Performance of Surgical Procedures. At the beginning of this 40 year period of expansion it is believed that every state's optometry Act except for the laws in Idaho, Indiana, Oklahoma, and Washington state included language prohibiting, in some manner, the performance of surgery. However, certain procedures routinely performed by optometrists, and not normally considered surgery as that term is traditionally understood, have surgical reimbursement codes assigned to them. Primarily for reimbursement reasons, legislation was enacted in the majority of states to make it clear that certain surgical procedures, such as the removal of foreign bodies, are included in the practice of optometry. Until such time as a state legislature repeals a prohibition against performing surgery, defining certain surgical procedures as within the scope of optometric practice and hence not included in any prohibition against performing surgery, was, and continues to be, the approach in most states.

<u>Historical Timeline – Diagnostic Pharmaceutical Agents (DPAs)</u>

While the first law specifically authorizing the use of diagnostic drugs to facilitate the examination was enacted in Rhode Island in 1971, in fact there were two other states prior to 1971 where use of diagnostic drugs by optometrists received favorable Attorney General opinions based on an interpretation of the optometry Act in effect at the time.

In Indiana there was a favorable Attorney General opinion dated July 17, 1946, affirming that the optometry Act, as reenacted in 1935, authorized the use of legend drugs by optometrists. "Prior to 1935, optometric drug use in patient care was prohibited by law, but the 1935 Indiana Legislature saw fit to remove that restriction and allow optometrists to practice to the fullest extent of their education and clinical experience." [6] Legislation was later considered and defeated by the Indiana legislature that would have prohibited pharmaceutical use – lending weight to the view of the Attorney General that diagnostic and prescriptive authority were authorized under the Indiana optometry law. In addition, in 1980, organized ophthalmology challenged that interpretation of the Indiana optometry law in court. The suit was eventually dismissed by the state Court of Appeals in 1985. [7]

In New Jersey there was a favorable Attorney General directive issued to the New Jersey State Board of Medical Examiners dated May 22, 1968, that said the optometry Act in effect at that time authorized optometrists to use a local anesthetic to perform corneal tonometric examinations.

Both states went on to enact clarification legislation at a later date making it unambiguous that the use (Indiana

and New Jersey) or the prescription (Indiana) of drugs was included in the practice of optometry.

It took almost 18 years from the Rhode Island victory on July 16, 1971 until January 13, 1989 when Maryland became the last state authorizing the use of diagnostic drugs to facilitate the examination. However, when considering the fact that varying opposing interests both internal and external to the profession along with innumerable political and legislative hurdles had to be overcome in 51 separate jurisdictions in order to enact similar legislation, 18 years was a relatively short period of time in the 110 year history of optometry as a legislated profession. (On December 28, 1982 and August 15, 1999, respectively, the U.S. territory of Guam and the Commonwealth of Puerto Rico also enacted diagnostic authority legislation.)

Historical Timeline – Diagnosis of Disease

It is apparently lost to history which state law first established the legal duty for optometrists to "diagnose" diseases or conditions of the eye and vision system vs. "detect," "ascertain," or "recognize." Such authority was most likely in place in some states before the first diagnostic or therapeutic laws were enacted. However, we do know the year the last practice Act was amended establishing the legal requirement for optometrists in every state and the District of Columbia to diagnose disease.

The last state to amend "ascertain" or "detect" to "diagnose." On May 11, 2004, Vermont Senate Bill 54 was enacted amplifying previous law that had authorized the prescription of limited topical drugs, excluding those used to treat glaucoma. The 2004 amplification law – one in a series of amplification victories in Vermont over a period of several years – authorized the use and prescription of all topical and oral drugs, including injectables for anaphylaxis. In addition, this Act added authority to treat glaucoma and added specific language affirming the authority of Vermont optometrists to treat the lacrimal gland and use punctal plugs.

Of historical import, the 2004 Act amended the law replacing the language "ascertain" and "detecting the possible presence of" with "diagnosing." This concluded a decades-long effort to clarify, if not elevate, the legal duty of optometrists in every state to **diagnose** diseases and conditions of the eye and related structures, a responsibility entirely appropriate for doctoral level, independent, learned healthcare providers.

Historical Timeline – Therapeutic Pharmaceutical Agents (TPAs)

On March 4, 1976,West Virginia was the first state to enact legislation specifically granting optometrists the right to prescribe legend (prescription) drugs for their patients and the District of Columbia was the last jurisdiction to do so on April 22, 1998 – a period of 22 years. (On April 22, 1995, the U.S. territory of Guam also enacted therapeutic prescriptive authority legislation.)

Only five states enacted legislation authorizing diagnostic (DPA) and at least some therapeutic (TPA) drugs in the same law [See Table 1].

Full therapeutic (TPA) authority was not gained, except in very few jurisdictions, all in one legislative victory. **Only four states enacted laws granting full TPA authority in one bill.** [See Table 2].

Prescriptive authority achieved in the initial therapeutic legislative victories was not in any way uniform from state to state. Table 3 illustrates many of the incremental steps of scope of practice/prescriptive authority expansion required in the vast majority of the states. Because of the great number of legislative successes, even this Table does not provide the luxury of space that would be required to illustrate every single incremental victory expanding optometry into medical eye care.

For example:

- Six states did not achieve topical steroid authority with their initial therapeutic law [See Table 4];
- Twenty-six states gained topical drug prescriptive authority only with their initial therapeutic law and had to go back to the legislature at a later date to gain oral drug authority (in fact, at this time three jurisdictions remain without any oral drug authority);
- Twenty-six states and the District of Columbia gained glaucoma treatment with their initial therapeutic law (albeit many with topical drugs only) while the rest had to go back later to gain authority to treat glaucoma (in fact, at this time one state remains without the authority to treat glaucoma);
- Only ten states gained controlled narcotic substance authority with their initial therapeutic law (in fact, at this time seven states and the District of Columbia remain without any controlled narcotic substance authority);
- Only nine states and the District of Columbia gained authority with their initial therapeutic law to use injectable agents to treat an anaphylactic reaction or to diagnose or treat disease (in fact, at this time 15 states remain without injectables authority of any type);
- Some states were initially required to use or prescribe drugs from a formulary – most did not;
- Many states gained certain drugs or classes of drugs and had to go back later for additional drugs or classes of drugs – or repeal the limitations altogether; and
- Some states initially had to accept multiple statutorily-defined standard of care or other conditions, restrictions, or limitations on the use or prescription of drugs to treat diseases or conditions of the eye [See Figure 1].

The fact is that many of the states and the District of Columbia must still pursue additional amplification legislation in order to fully establish a prescriptive authority law that meets the criteria for uniformity described below.

For political and practical reasons, principally because the various state laws are written style-wise so differently from each other, there is no recommended uniform prescriptive authority language. However, there is a uniform prescriptive authority end point result.

A uniform prescriptive authority law is a tangible concept. While there is no ***model*** language there is a ***model result***; it is the ***effect*** of a state's practice Act, not the precise language of the law. The statutory language establishing uniform prescriptive authority can be written in as many ways as there are practice Acts. The goal is for the optometry law to authorize the use and prescription of all appropriate or necessary legend (prescription) and over-the-counter drugs, including controlled narcotic substances, via any route of administration for the diagnosis, treatment, and management of conditions of the vision system, eye, and related structures. As with other classes of independent doctoral-level prescribing professions (e.g., allopathic or osteopathic medical physicians, dentists, and podiatrists) an optometry license issued or renewed today should automatically include full prescriptive authority. And importantly, there should be no statutorily defined conditions, restrictions, limitations, or other standard of care-type language codified into the practice Act by the state legislature.

While the legislature is the only body in each state empowered to set the general parameters of scope of practice for the various regulated professions, the legislature, whose vast majority of members are not educated and trained as healthcare providers, shouldn't be practicing the mechanics of health care by defining in statute how specific services or procedures are to be provided, under what circumstances patients should be referred, or which medications are appropriate for a certain condition. These medical decisions, made for an individual patient, should be left to the independent professional judgment of all doctoral-level healthcare providers, each of whom is held to a standard of care and expected to practice appropriately without such statutorily spelled out mandates.

A uniform scope of practice law is a tangible concept. Quite simply, an optometry license, as authorized by

the state legislature, should allow licensees to examine, diagnose, treat, and manage diseases or conditions of the vision system, eye, and related structures with any appropriate means. This includes every facet of the practice of modern optometry, from the use of lenses and prisms; to the provision or prescription of ocular exercises, vision therapy, and vision rehabilitation; to the prescription, fitting, dispensing, and sale of corrective eyewear and contact lenses, including plano or cosmetic lenses; to the ordering or performing of appropriate diagnostic or imaging tests; to the use or prescription of appropriate drugs, including controlled narcotic substances; to the performance of non-surgical and surgical procedures.

While the concept has gone through philosophical and statutory changes over the decades, the more than 180 expansion and amplification laws enacted over the past 40 years in the various states and the District of Columbia have strived to achieve, albeit oftentimes in incremental steps, a uniform medical eye care scope of practice among the jurisdictions.

Historical Timeline – Performance of Surgical Procedures

The performance of certain procedures that are assigned Current Procedural Terminology (CPT®)[8] surgical reimbursement codes began on March 4, 1976 with passage of West Virginia House Bill 1005, the first therapeutic law. The legislature established the scope of practice of optometry in 1976 in West Virginia as :

"§30-8-2. Practice of optometry defined.

Any one or any combination of the following practices shall constitute the practice of optometry:

(c) The employment **without the use of surgery** *of any instrument, device, method or diagnostic or therapeutic drug for topical application to the anterior segment of the human eye intended for the purpose of investigating, examining,* ***treating****, diagnosing, improving or* ***correcting any*** *visual defect or* ***abnormal condition of the human eye or its appendages****;" [emphasis added]*

Nowhere in the 1976 West Virginia law was surgery defined. And since removal of superficial foreign bodies and treatment of the lacrimal drainage system do not involve cutting, suturing, or use of a local or general anesthetic (all components of surgery as that term might commonly be defined), performing these procedures was not prohibited.

The law enacted one year later on June 3, 1977 in North Carolina authorized the use of diagnostic and therapeutic drugs in the same legislation. There were no restrictions or limitations placed by the legislature on which drugs or routes of administration were authorized. While the law enacted in 1977 included the use of injectable agents, it took a lengthy regulatory process before the North Carolina State Board of Examiners in Optometry authorized their use by optometrists to perform certain procedures or diagnostic tests. The legislature established the scope of practice of optometry in North Carolina in 1977 as:

"§90 – 114. Optometry defined. Any one or any combination of the following practices shall constitute the practice of optometry:

(2) the employment of instruments, devices, pharmaceutical agents and procedures, ***other than surgery,*** *intended for the purposes of investigating, examining, treating, diagnosing or correcting visual defects or abnormal conditions of the human eye or its adnexa; or" [emphasis added]*

The removal of foreign bodies, use of punctal plugs, and other services/procedures not commonly defined to be "surgery" as that term is generally understood were not prohibited.

First state to specifically authorize removal of superficial foreign bodies. Iowa (the sixth state to enact a therapeutic law) enacted Senate Bill 438 on May 31, 1985, becoming the first state optometry law to specifically reference the authority of an optometrist to remove foreign bodies:

"Section 154.1 (new section):

Therapeutically certified optometrists may employ the following pharmaceuticals: topical antimicrobial agents, topical and oral antihistamines, topical anti-inflammatory agents, topical analgesic agents and topical anesthetic agents. ***Superficial foreign bodies may be removed from the human eye and adnexa.*** *. . ."* [emphasis added]

As therapeutic laws were enacted and/or amplified in other states, a specific reference to the removal of foreign bodies (generally limited to "superficial" foreign bodies) was included in almost every practice Act, which served to prevent inaccurate interpretations of the law by third party payers when optometrists sought reimbursement for performing the procedure.

Other surgical procedures. Over time, in some states additional surgical procedures such as treatment of the lacrimal drainage system, chalazion, or concretions have been 1) added to the definition of the practice of optometry, 2) exempted from a prohibition against the performance of surgery, or 3) deemed authorized because they were not specifically excluded. The authority to use an injectable drug of some type may be necessary to perform some of these procedures.

The use of lasers for therapeutic purposes. [See Table 5]

Oklahoma Laser Authority. Oklahoma optometrists have been performing laser and non-laser surgical procedures since as early as 1988. In 1988Oklahoma was one of only four states where the law at that time did not have a specific prohibition against the performance of surgery in the optometry Act.

Minutes from the February 21, 1988 meeting of the Oklahoma Board of Examiners in Optometry reflected a recognition by the board that *"when medically necessary, a qualified optometrist may utilize lasers, remove said stitches, and foreign bodies."* In 1989 the optometry board approved a certification process licensees were required to complete in order to become authorized to use lasers for therapeutic purposes.

In 1993 the Oklahoma State Medical Association (OSMA) found a sponsor for legislation seeking to prohibit optometrists from using lasers. The legislation (Senate Bill 883) did not apply to podiatrists, veterinarians, osteopathic physicians, or dentists. The sponsor pulled the bill prior to consideration. That same year, the OSMA sought an Attorney General opinion that the use of lasers by optometrists was not authorized. Attorney General Loving declined to issue an opinion.

In response to efforts by the OSMA causing Medicare and Medicaid to discontinue paying optometrists for these services, the optometry board issued a formal declaratory ruling in 1994 stating that lasers were within the scope of practice of optometry. Both Medicare and Medicaid resumed reimbursing optometrists.

1994 saw the enactment of a scope of practice expansion bill in Oklahoma when Senate Bill 818 was signed into law by Governor David Walter on April 13, 1994. This legislation repealed the limitation on prescriptive authority to topical agents only, but the law continued to remain silent on surgery (i.e., there was no prohibition against performing surgery) [deletions indicated by ~~strikethrough~~, additions indicated by <u>underscore</u>]:

"Section 581. The practice of optometry is defined to be the science and art of examining the human eye and measurement of the powers of vision by the employment of any means, including the use or furnishing of any self-testing device, the use of any computerized or automatic refracting device, the use of ocular pharmaceutical agents ~~topically~~

~~applied~~, the diagnosis of conditions of the human eye and the correcting and relief of ocular abnormalities by means including but not limited to prescribing and adaptation of lenses, contact lenses, spectacles, eyeglasses, prisms and the employment of visual training or orthoptics for the aid thereof. The practice of optometry shall also include the prescribing of dangerous drugs and controlled dangerous substances for all schedules specified in the Uniform Controlled Dangerous Substances Act except Schedules I and II for the purpose of diagnosis and treatment of ocular abnormalities. Provided, however, the practice of optometry shall not include the dispensing of drugs. This shall not preclude the dispensing of professional samples to patients."

Also in 1994, the OSMA found a sponsor for legislation to define lasers as surgery and prohibit their use by optometrists. However, Senate Bill 103 failed in Senate Committee.

The next year, the Oklahoma Board of Medical Licensure and Supervision sued the Board of Examiners in Optometry in an attempt to stop optometrists from using lasers. An Oklahoma District Court ruled the medical board did not have authority to sue the optometry board. The Court of Appeals concurred with the decision. However, in 1996 the Oklahoma Supreme Court overruled the District Court and the Court of Appeals.

This decision spurred the introduction of Senate Bill 995 in 1996 seeking to eliminate the Board of Medical Licensure and Supervision's ability to file suit against other licensing boards. The legislation passed when it was signed into law by Governor Frank Keating.

In 1997 Judge Eugene Mathews ruled in Oklahoma County District Court that the optometry Act did not authorize laser surgery and that only legislative action could accomplish this result.

Senate Bill 1192 was introduced in 1998 to codify and reinstate the previous privileges of optometrists to perform certain laser surgery procedures. The legislation was signed into law by Governor Frank Keating on March 16 that year.

The scope of practice as amended by the 1998 legislation was as follows (language specifically referencing the authority to perform laser surgical procedures was added) [deletions indicated by ~~strikethrough~~, additions indicated by underscore]:

"Section 581. A. The practice of optometry is defined to be the science and art of examining the human eye and measurement of the powers of vision by the employment of any means, including the use or furnishing of any self-testing device, the use of any computerized or automatic refracting device, the use of pharmaceutical agents, the diagnosis of conditions of the human eye and the correcting and relief of ocular abnormalities by means including but not limited to prescribing and adaptation of lenses, contact lenses, spectacles, eyeglasses, prisms and the employment of ~~visual training~~ vision therapy or orthoptics for the aid thereof, low vision rehabilitation, laser surgery procedures, excluding retina, laser in-situ keratomileusis (LASIK), and cosmetic lid surgery.

B. The practice of optometry shall also include the prescribing of dangerous drugs and controlled dangerous substances for all schedules specified in the Uniform Controlled Dangerous Substances Act except Schedules I and II for the purpose of diagnosis and treatment of ocular abnormalities. ~~Provided, however, the~~ The practice of optometry shall not include the dispensing of drugs~~. This shall not preclude~~ but may include the dispensing of professional samples to patients.

C. Optometrists shall be certified by the Board of Examiners in Optometry prior to administering drugs, prescribing drugs, or performing laser surgery procedures.

D. Nothing in this title shall be construed as allowing any agency, board, or other entity of this state other than the Board of Examiners of Optometry to determine what constitutes the practice of optometry."

In 2004 organized medicine sought another Attorney General opinion, this time asking whether the optometry law, as amended in 1998, authorized the performance of any surgery **other than** laser surgery. Organized medicine got the opinion they were looking for when the Attorney General opined that the optometry board could not interpret the statute as allowing licensees to perform any surgery other than laser surgery.

The optometry board was able to convince the Attorney General to pull and then revise that opinion – a very rare action on the part of any Attorney General. But, based on the revised Attorney General's opinion, the Oklahoma Association of Optometric Physicians found it necessary to go back to the legislature again to clarify the authority of optometrists to perform surgeries other than laser surgery.

The first Attorney General opinion issued on March 15, 2004 (Okl. A.G. Opin. No. 04-9):

"It is, therefore, the official Opinion of the Attorney General that:

1. Title 59 O.S. 2001, § 581 does not authorize licensed optometrists to perform any surgical procedures other than laser surgery procedures (excluding retina surgery, laser in-situ keratomileusis (LASIK) surgery and cosmetic lid surgery).

2. Title 59 O.S. 2001, § 581 does not authorize the Board of Examiners in Optometry to determine that licensed optometrists are authorized to perform surgical procedures other than laser surgery procedures (excluding retina surgery, laser in-situ keratomileusis (LASIK) surgery and cosmetic lid surgery)."

W.A. Drew Edmondson, Attorney General Of Oklahoma

Debra Schwartz, Assistant Attorney General

The revised Attorney General opinion issued on April 6, 2004 (Okl. A.G. Opin. No. 04-9):

"It is, therefore, the official Opinion of the Attorney General that:

1. Title 59 O.S. 2001, § 581 does not authorize licensed optometrists to perform any surgeries other than laser surgeries (excluding retina surgery, laser in-situ keratomileusis (LASIK) surgery and cosmetic lid surgery).

2. Title 59 O.S. 2001, § 581 does not authorize the Board of Examiners in Optometry to determine that licensed optometrists are authorized to perform surgeries other than laser surgeries (excluding retina surgery, laser in-situ keratomileusis (LASIK) surgery and cosmetic lid surgery).

*3. **Whether any particular procedure constitutes surgery is a question of fact which cannot be answered in an Attorney General's Opinion.** 74 O.S. 2001, § 18 b(A)(5).* [emphasis added]

4. This Opinion replaces the previous version of Opinion 04-9 dated March 15, 2004, which is hereby withdrawn."

W.A. Drew Edmondson, Attorney General Of Oklahoma

Debra Schwartz, Assistant Attorney General

On April 21, 2004, House Bill 2321 was enacted clarifying that in addition to laser surgery procedures, non-laser surgery procedures (as defined by the optometry board) were included in the scope of practice. As charged by the legislature, the optometry board promulgated an emergency rule in October 2004 defining

non-laser surgery. The emergency rule was made final through legislative approval in 2005. The rule adopted by the optometry board established a list of those surgical procedures that are excluded from the scope of services optometrists may perform.

The scope of practice as amended by the 2004 legislation was as follows [deletions indicated by ~~strike-through~~, additions indicated by underscore]:

"Section 581. A. The practice of optometry is defined to be the science and art of examining the human eye and measurement of the powers of vision by the employment of any means, including the use or furnishing of any self-testing device, the use of any computerized or automatic refracting device, the use of pharmaceutical agents, the diagnosis of conditions of the human eye and the correcting and relief of ocular abnormalities by means including but not limited to prescribing and adaptation of lenses, contact lenses, spectacles, eyeglasses, prisms and the employment of vision therapy or orthoptics for the aid thereof, low vision rehabilitation, laser surgery procedures, excluding retina, laser in-situ keratomileusis (LASIK), and cosmetic lid surgery. The practice of optometry is further defined to be non laser surgery procedures as authorized by the Oklahoma Board of Examiners in Optometry, pursuant to rules promulgated under the Administrative Procedures Act.

B. The practice of optometry shall also include the prescribing of dangerous drugs and controlled dangerous substances for all schedules specified in the Uniform Controlled Dangerous Substances Act except Schedules I and II for the purpose of diagnosis and treatment of ocular abnormalities. The practice of optometry shall not include the dispensing of drugs but may include the dispensing of professional samples to patients.

C. Optometrists shall be certified by the Board of Examiners in Optometry prior to administering drugs, prescribing drugs, or performing laser or nonlaser surgery procedures.

D. Nothing in this title shall be construed as allowing any agency, board, or other entity of this state other than the Board of Examiners of in Optometry to determine what constitutes the practice of optometry."

While optometrists in Oklahoma have safely and effectively performed thousands of non-laser and laser surgical procedures since 1988, it took years of legal and legislative battles to clarify this authority.

Kentucky Laser Authority. In comparison to Oklahoma, the Kentucky experience establishing authority for optometrists to perform laser and non-laser surgery was not as complicated, nor drawn out. Having the benefit of the Oklahoma experience as a guide, the Kentucky Optometric Association drafted language for bill introduction in the 2011 legislative session that clearly and incontrovertibly defined the authority of optometrists to perform surgery and laser surgery; with the exception of 17 procedures. Senate Bill 110 was overwhelmingly supported by state legislators and signed into law by Governor Steve Beshear on February 24, 2011.[9]

The Kentucky Board of Examiners in Optometry was charged by the state legislature in Senate Bill 110 with promulgation of regulations to define the education and training required of optometrists in order to be authorized to perform the newly granted surgery and laser surgery privileges.

The five most significant features of Senate Bill 110 expanding the scope of practice for optometrists in Kentucky are, in ascending order:

5. Made crystal clear the optometry board's authority — **within the constraints of the law as enacted by the legislature** — to explain (interpret) the practice Act, including scope of practice (the new language reinforced authority the board already held);

4. While adding the authority to perform laser and non-laser surgical procedures, the Act retained all of the basic fundamental components of optometric scope of practice including, but not limited to such services as: the examination, diagnosis, and treatment of the human eye and its appendages to correct and relieve ocular abnormalities and to determine eye health, the visual efficiency of the human eye, or the powers or defects of vision in any authorized manner; the use of autorefractors or any other testing means or devices; the prescribing, furnishing, use, or adapting of lenses, contact lenses, spectacles, eyeglasses, prisms, or ocular devices; and the employing of vision therapy, orthoptics, ocular exercises, or low vision rehabilitation;

3. Made clear the authority of optometrists to use or prescribe any drug via any route of administration (with the exception of Schedule I and II controlled narcotic substances, laser or nonlaser injections into the posterior chamber of the eye to treat any macular or retinal disease, or the administration of general anesthesia);

2. For the first time in any state, a state official during a public health emergency may authorize optometrists to administer vaccinations or immunizations for systemic health reasons; and

1. For the first time in any state, a legislature repealed a prohibition against the performance of surgery by optometrists.[10]

Conclusion

Seventy years after optometrists were first licensed in the United States as a profession there began a 40 year curriculum and statutory scope of practice expansion effort that initiated a sweeping transformation of the profession from the expert, but "drugless" refractionists of the early 1900's, to detecting and referring eye disease at mid-Century, to today's largest eye and vision care profession, providing patients access to safe and effective vision and medical eye care from their local doctor of optometry.

However, it may take another decade or more of intensive grassroots legislative activity to establish a more uniform medical eye care scope of practice among the various jurisdictions and complete the journey started 40 years ago in Rhode Island.

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References:

1 Wolfberg MD. Remembrance of things past – A profession's commitment to increased public service: optometry's remarkable story. J Am Optom Assoc 1999; 70:145-170.

2MinnesotaSenate Bill 188, Approved April 13, 1901.

3 According to the American Medical Association's Physician Masterfile (updated July 7, 2008), there are

23,861 ophthalmologists in the U.S. That number includes both active and inactive (retired, etc.) ophthalmologists. As referenced by the American Academy of Ophthalmology at http://www.aao.org/newsroom/press_kit/upload/Eye-Health-Statistics-June-2009.pdf, accessed October 5, 2011

4 Based on projections, there were 38,758 full-time equivalent optometrists in the workforce during 2010. Caring for the Eyes of America 2010, a Profile of the Optometric Profession, American Optometric Association, 2010

5 An example of a scope expansion law that included a sunset date which would have repealed the authority granted unless the sunset date was extended or removed by the legislature was Senate Bill 2356 enacted in North Dakota on March 22, 1979. This law expanded the scope of practice by authorizing the use of diagnostic pharmaceutical agents. Contained in the law was a provision that the authority of the optometry board to certify licensees to use diagnostic agents would sunset (expire) on June 30, 1981. However, on March 9, 1981, North Dakota Governor Allen Olson signed Senate Bill 2222 into law repealing the sunset provision and reaffirming the authority of the board to grant diagnostic certification to licensees who met board-approved education and training requirements.

6 Wuensch, RW. Memorandum to the membership of the Indiana Optometric Association; October 31, 1985.

7 ibid

8 CPT® is a registered trademark of the American Medical Association.

9KentuckySenate Bill 110 passed the Senate on February 11 by a vote of 33 to 3 (with one pass) and the House on February 18 with a vote of 81 to 14. The bill was signed into law by the Governor on February 24, 2011.

10 When enacting Senate Bill 110 repealing the prohibition against the performance of surgery by optometrists, the Kentucky legislature excluded, except for the pre-operative and post-operative care of these procedures, the following from the authority granted to perform laser and non-laser surgery:

1. Retina laser procedures, LASIK, and PRK;

2. Nonlaser surgery related to removal of the eye from a living human being;

3. Nonlaser surgery requiring full thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of the pressure inside the eye;

4. Penetrating keratoplasty (corneal transplant), or lamellar keratoplasty;

5. Nonlaser surgery requiring incision of the iris and ciliary body, including iris diathermy or cryotherapy;

6. Nonlaser surgery requiring incision of the vitreous;

7. Nonlaser surgery requiring incision of the retina;

8. Nonlaser surgical extraction of the crystalline lens;

9. Nonlaser surgical intraocular implants;

10. Incisional or excisional nonlaser surgery of the extraocular muscles;

11. Nonlaser surgery of the eyelid for eyelid malignancies or for incisional cosmetic or mechanical repair of

blepharochalasis, ptosis, and tarsorrhaphy;

12. Nonlaser surgery of the bony orbit, including orbital implants;

13. Incisional or excisional nonlaser surgery of the lacrimal system other than lacrimal probing or related procedures;

14. Nonlaser surgery requiring full thickness conjunctivoplasty with graft or flap;

15. Any nonlaser surgical procedure that does not provide for the correction and relief of ocular abnormalities;

16. Laser or nonlaser injection into the posterior chamber of the eye to treat any macular or retinal disease; and

17. The administration of general anesthesia.

Figure 1

Examples Of Statutorily Defined Standard Of Care-Type Conditions, Restrictions, Or Limitations

NOTE: Depending on the diagnosis, progress, or unique circumstances of individual patients, every doctoral-level healthcare practitioner, based on his or her independent professional judgment and within appropriate standard of care guidelines for that profession, has a legal and ethical duty in some cases to limit the services they provide and/or refer the patient to another provider. However, based on the reality of political compromise that is sometimes required to enact legislation, over the years the legislature in more than one state has codified a requirement in the optometry Act to do for all patients what should be a professional medical judgment decision made for an individual patient. These mandatory "standard of care"-type provisions applying to all patients have been and continue to be repealed as part of the effort to establish more uniform scope of practice laws among the various jurisdictions.

Conditions?

- An optometrist is required by statute to consult an ophthalmologist before, or shortly after, initiating treatment of all patients newly diagnosed with glaucoma.
- An optometrist is required to refer all patients with a certain condition or disease to a medical physician if there is no improvement within a statutorily defined period of time.

Restrictions?

- An optometrist can prescribe a particular medication, but never for more than a statutorily defined period of time.
- An optometrist can prescribe a particular medication, but only to treat certain statutorily defined specific diseases.
- An optometrist is authorized to prescribe a particular medication, but in its topical form only.

Limitations?

- An optometrist can only prescribe medications within certain statutorily defined classes of drugs.
- An optometrist can only prescribe medications listed on a statutorily required formulary.
- An optometrist is prohibited from treating certain diseases or disorders of the eye.

Table 1

States Where Diagnostic Use And Therapeutic Prescriptive Authority Were Enacted In The Same Legislation

STATE:	DIAGNOSTIC AND THERAPEUTIC AUTHORITY*
FLORIDA**	July 10, 1986
INDIANA**	May 13, 1991
NEWJERSEY**	January 16, 1992
NORTH CAROLINA	June 3, 1977
WEST VIRGINIA	March 4, 1976

FOOTNOTE:

* Some states went on at a later date to amplify the therapeutic authority gained in the original legislative victory.

** The legislation enacted in Florida and New Jersey in reference to diagnostic drug authority and in Indiana in reference to diagnostic and therapeutic prescriptive authority clarified earlier favorable Attorney General opinions based on the law at that time.

Table 2

States Where Full Prescriptive Authority Was Obtained In The Initial Therapeutic Law

[NOTE: This includes topical and oral drugs, the treatment of glaucoma, controlled narcotic substances, and use of injectables of some type.]

STATE:	FIRST TPA LAW	GLAUCOMA Tx	ORALS	CONTROLLED SUBSTANCES	INJECTABLES (anaphylaxis or other)
Alabama	June 20, 1995 (43)	June 20, 1995 (30)	June 20, 1995 (25)	June 20, 1995 (18)	June 20, 1995 (12)
North Carolina*	June 3, 1977 (2)	June 3, 1977 (2)	June 3, 1977 (1)	June 3, 1977 (1)	June 3, 1977 (1)
Utah**	March 20, 1991 (26)	March 20, 1991 (13)	March 20, 1991 (10)	March 20, 1991 (8)	March 20, 1991 (4)
Wisconsin***	August 3, 1989 (25)	August 3, 1989 (12)	August 3, 1989 (8)	August 3, 1989 (6)	August 3, 1989 (3)

The number in parentheses following the enactment date is the ranking order of enactment compared to the other states. For example, Alabama passed the 43rd TPA law, the 30th glaucoma treatment law, the 25th orals authority law, the 18th controlled substance authority law, and the 12th law allowing for the use of injectable agents of some type.

FOOTNOTES:

* The law enacted in North Carolina in 1977 authorized the use and prescription of all drugs. In 2005, policy was adopted by the State Board of Examiners in Optometry whereby optometrists meeting specific educational requirements were allowed to use injections for the treatment of chalazia, to perform peri-ocular injections for purposes other than for cosmesis, and to perform fluorescein angiography.

** The law enacted in Utah in 1991 authorized optometrists to prescribe drugs, but required optometrists at that time to prescribe drugs through protocols developed with supervising ophthalmologists. The only drugs excluded by the 1991 statute were Schedule II and III controlled narcotic substances. However, the protocols developed by individual supervising ophthalmologists may or may not have limited prescription to certain drugs only. The law was amended in 1997 when the supervision requirement was repealed and authority to prescribe oral drugs was clarified. The law was again amended in 2000 repealing the prohibition on the prescription of Schedule III controlled narcotic substances.

*** The law enacted in Wisconsin in 1989 required use of a formulary that still exists today. The only drugs specifically excluded by that law were Schedule I and II controlled narcotic substances. The formulary developed to implement the law contained a long list of drugs authorized for prescription. Rule making in April 1994 amended the formulary one final time to add authority to prescribe "any drug which is used for an ophthalmic therapeutic purpose."

Table 3

The Date Legislation Was First Enacted Authorizing The Prescription Of Drugs, Glaucoma Drugs, Oral Drugs, Controlled Narcotic Substances, Or Use Of Injectable Agents

[NOTE: The majority of the initial therapeutic laws were amplified in subsequent years, some multiple times.]

As of February 23, 2012

STATE:	FIRST TPA LAW (Rx any legend drugs)	GLAUCOMA Tx (Rx any topical or topical & oral)	ORALS (Rx any orals)	CONTROLLED SUBSTANCES (Rx any orals)	INJECTABLES (anaphylaxis or anaphylaxis & other)
Alabama	June 20, 1995 (43)	June 20, 1995 (30)	June 20, 1995 (25)	June 20, 1995 (18)	June 20, 1995 (12)
Alaska	June 11, 1992 (32)	June 11, 1992 (17)	Sept 7, 2007 (46)	Sept 7, 2007 (41)	Sept 7, 2007 (31)
Arizona	April 6, 1993 (33)	April 6, 1993 (19)	May 18, 1999 (36)	May 18, 1999 (28)	May 18, 1999 (19)

Arkansas	March 3, 1987 (14)	March 3, 1987 (9)	Feb 17, 1997 (33)	Feb 17, 1997 (24)	Feb 17, 1997 (17)
California	Feb 20, 1996 (47)	Sept 24, 2000 (45)	Feb 20, 1996 (28)	Sept 24, 2000 (31)	Sept 24, 2000 (21)
Colorado	April 20, 1988 (23)	June 8, 1996 (37)	April 20, 1988 (7)	April 20, 1988 (5)	April 22, 2011 (34)
Connecticut	May 27, 1992 (31)	May 8, 1996 (36)	May 27, 1992 (12)	May 8, 1996 (22)	May 8, 1996 (16)
Delaware	June 30, 1994 (40)	June 30, 1994 (27)	June 30, 1994 (21)		
D.C.	April 22, 1998 (50B)	April 22, 1998 (41B)	April 22, 1998 (34B)		April 22, 1998 (17B)
Florida	July 10, 1986 (12)	July 10, 1986 (7)			
Georgia	Feb 25, 1988 (21)	April 8, 1994 (26)	April 8, 1994 (19)	April 8, 1994 (14)	
Hawaii	June 24, 1996 (48)	April 30, 2004 (48)	April 30, 2004 (42)		April 30, 2004 (26)
Idaho	March 31, 1987 (15)	March 22, 1993 (18)	March 22, 1993 (13)	March 22, 1993 (9)	March 22, 1993 (6)
Illinois	July 14, 1995 (45)	July 14, 1995 (31)	July 14, 1995 (27)	August 17, 2007 (40)	August 17, 2007 (30)
Indiana	May 13, 1991 (3)*	May 13, 1991 (3)*	May 13, 1991 (3)*		
Iowa	May 31, 1985 (6)	May 7, 1987 (10)	May 31, 1985 (2)	May 7, 1987 (4)	March 28, 2002 (23)
Kansas	April 17, 1987 (17)	April 1, 1996 (34)	March 23, 1999 (35)	March 23, 1999 (27)	
Kentucky	Feb 7, 1986 (8)	Feb 7, 1986 (6)	March 25, 1996 (30)	March 25, 1996 (20)	March 25, 1996 (15)
Louisiana	June 1, 1993 (36)	June 1, 1993 (23)	June 1, 1993 (16)	May 27, 2005 (39)	June 1, 1993 (8)
Maine	June 25, 1987 (20)	April 2, 1996 (35)	April 2, 1996 (31)	April 2, 1996 (21)	July 3, 1995 (13)
Maryland	May 25, 1995 (42)	May 25, 1995 (28)	May 25, 1995 (24)**		May 25, 1995 (11)

Massachusetts	July 31, 1997 (50)				
Michigan	Dec 29, 1994 (41)	Dec 1, 1997 (40)	Dec 13, 2002 (39)	Dec 13, 2002 (33)	
Minnesota	May 11, 1993 (34)	May 11, 1993 (21)	May 19, 2003 (41)	May 19, 2003 (35)	May 19, 2003 (25)
Mississippi	April 7, 1994 (38)	April 7, 1994 (25)	March 16, 2005 (45)	March 16, 2005 (38)	March 16, 2005 (28)
Missouri	June 24, 1986 (11)	May 31, 1995 (29)	June 24, 1986 (4)	June 24, 1986 (2)	
Montana	April 23, 1987 (19)	Feb 24, 1999 (42)	April 23, 1987 (6)	April 23, 1987 (3)	Feb 24, 1999 (18)
Nebraska	March 26, 1986 (10)	March 3, 1998 (41)	June 10, 1993 (17)	June 10, 1993 (12)	
Nevada	June 29, 1995 (44)	May 29, 1999 (43)	June 29, 1995 (26)	May 29, 1999 (29)	
New Hampshire	June 29, 1993 (37)	May 18, 2002 (46)	June 29, 1993 (18)	June 29, 1993 (13)	June 29, 1993 (9)
New Jersey	January 16, 1992 (29)	January 16, 1992 (15)	August 7, 2004 (44)	August 7, 2004 (37)	January 16, 1992 (5)
New Mexico	April 5, 1985 (5)	April 5, 1985 (5)	March 17, 1995 (23)	March 17, 1995 (17)	April 2, 2007 (29)
New York	August 2, 1995 (46)	August 2, 1995 (32)			
North Carolina	June 3, 1977 (2)	June 3, 1977 (2)	June 3, 1977 (1)	June 3, 1977 (1)	June 3, 1977 (1)
North Dakota	April 10, 1987 (16)	March 23, 1997 (39)	April 10, 1987 (5)	March 23, 1997 (25)	April 10, 1987 (2)
Ohio	Feb 15, 1992 (30)	Feb 15, 1992 (16)	Feb 15, 1992 (11)	Dec 21, 2007 (42)	Dec 21, 2007 (32)
Oklahoma	March 22, 1984 (4)	March 22, 1984 (4)	April 13, 1994 (20)	April 13, 1994 (15)	April 13, 1994 (10)
Oregon	August 9, 1991 (28)	August 9, 1991 (14)	June 27, 2001 (38)	June 27, 2001 (32)	June 27, 2001 (22)
Pennsylvania	Oct 30, 1996 (49)	Dec 16, 2002 (47)	Oct 30, 1996 (32)	Oct 30, 1996 (23)	

Rhode Island	June 26, 1985 (7)	March 20, 1997 (38)	July 8, 2008 (47)	July 8, 2008 (43)	
South Carolina	May 14, 1993 (35)	May 14, 1993 (22)	May 14, 1993 (15)	May 14, 1993 (11)	
South Dakota	March 15, 1986 (9)	Feb 22, 1994 (24)	Feb 26, 1991 (9)	Feb 26, 1991 (7)	
Tennessee	April 22, 1987 (18)	May 5, 1993 (20)	May 5, 1993 (14)	May 5, 1993 (10)	May 5, 1993 (7)
Texas	June 15, 1991 (27)	June 19, 1999 (44)	June 19, 1999 (37)	June 19, 1999 (30)	June 19, 1999 (20)
Utah	March 20, 1991 (26)	March 20, 1991 (13)	March 20, 1991 (10)	March 20, 1991 (8)	March 20, 1991 (4)
Vermont	June 20, 1994 (39)	May 11, 2004 (49)	May 11, 2004 (43)	May 11, 2004 (36)	May 11, 2004 (27)
Virginia	April 11, 1988 (22)	March 8, 1996 (33)	March 8, 1996 (29)	March 8, 1996 (19)	March 8, 1996 (14)
Washington	April 18, 1989 (24)	April 18, 1989 (11)	May 7, 2003 (40)	May 7, 2003 (34)	May 7, 2003 (24)
West Virginia	March 4, 1976 (1)	March 4, 1976 (1)	April 18, 1997 (34)	April 18, 1997 (26)	April 2, 2010 (33)
Wisconsin	August 3, 1989 (25)	August 3, 1989 (12)	August 3, 1989 (8)	August 3, 1989 (6)	August 3, 1989 (3)
Wyoming	March 2, 1987 (13)	March 2, 1987 (8)	Feb 16, 1995 (22)	Feb 16, 1995 (16)	

The number in parentheses following the enactment date for each state is the order of enactment compared to the other states. For example, Alabama passed the 43rd TPA law, the 30th glaucoma treatment law, the 25th orals authority law, the 18th controlled substance authority law, and the 12th law allowing for the use of injectable agents of some type. In the case of the District of Columbia, the number in parentheses followed by a "B" indicates that D.C. was the next jurisdiction in the order of enactment after the state with that same number.

Footnotes:

* General legislation, favorable attorney general opinion based on the law at that time. Legislation that would have prohibited pharmaceutical use defeated. Appeal from dismissal of litigation that would have prohibited pharmaceutical use denied by state supreme court, February 27, 1986. Clarification legislation adopted May 13, 1991.

** Tetracycline and its derivatives for the diagnosis and treatment of meibomitis and seborrheic blepharitis are the only oral drugs authorized.

Table 4

States Where Authority To Prescribe Topical Steroids Was Not Granted With Initial Therapeutic Legislation

STATE:	INITIAL THERAPEUTIC LAW:	LAW AUTHORIZING TOPICAL STEROIDS:
CALIFORNIA	February 20, 1996	September 24, 2000
HAWAII*	June 24, 1996	June 18, 2002
MARYLAND	May 25, 1995	May 10, 2005
MONTANA	April 23, 1987	April 12, 1993
NEW HAMPSHIRE	June 29, 1993	May 18, 2002
PENNSYLVANIA	October 30, 1996	December 16, 2002

FOOTNOTE:

* The Hawaii legislature did not prohibit the prescription of topical steroids in the initial prescriptive authority law enacted on June 24, 1996. However, the formulary committee in place at that time, which included two optometrists, two ophthalmologists, and two pharmacists, did not include topical steroids on the formulary of authorized drugs. Legislation to repeal the formulary committee and specifically clarify the authority of an optometrist to prescribe topical steroids was enacted on June 18, 2002.

Table 5

States Where The Use Of Lasers For Certain Therapeutic Purposes Is Authorized

STATE:	USE OF LASERS FOR THERAPEUTIC PURPOSES
Kentucky	February 24, 2011
Oklahoma*	March 16, 1998

* This Act codified and expanded on a recognition by the Oklahoma Board of Examiners in Optometry during a February 1988 board meeting, as recorded in the minutes of the meeting, that “when medically necessary, a qualified optometrist may utilize lasers, remove said stitches, and foreign bodies.”