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NOTES

EYE WARS: THE DEBATE OVER STANDARD OF CARE*

Optometrists, licensed health care professionals, have gained increased legislative approval for their use of diagnostic and therapeutic drugs. Ophthalmologists, licensed physicians, warn against this trend and argue that the increased access of optometrists to pharmaceuticals imperils health care consumers. This Note argues that in order to ensure quality eye care optometrists should be held to a standard of care comparable to the specialist standard required of ophthalmologists.

THE MEDICAL FIELD today is faced with growing demands from non-medical professional health groups which are determined to practice primary health care. These non-medical professionals seek increased participation in health care based on their right to practice "state of the art" treatment and their patients' right to obtain cost effective quality care. Medical professionals

* The author would like to thank her husband, John P. Douglas, whose ideas and support helped shape this Note.

1. See generally Kucera & Manson, Allied Health Professionals: An Opportunity and a Challenge, 16 Forum 787 (1981)(identifying the legal areas where changes are occurring due to the rapid expansion in the roles of allied health professionals and the challenges created for the existing health care delivery system); Robyn & Hadley, National Health Insurance and the New Health Occupations: Nurse Practitioners and Physicians' Assistants, 5 J. Health Pol. Pol'y & L. 447 (1980)(discussing issues arising in the formulation of policy regarding national health insurance and new health occupations, specifically nurse practitioners and physicians' assistants); Note, The Legal Status of Physician Extenders in Iowa: Review, Speculation, and Recommendations, 72 Iowa L. Rev. 215 (1986)(examining malpractice liability of physician extenders such as physicians' assistants and nurse practitioners with suggestions of appropriate standards of care); Note, Denial of Hospital Admitting Privileges for Non-Physician Providers — A Per Se Antitrust Violation?, 60 Notre Dame L. Rev. 724 (1985)(examining the application of federal antitrust law to hospitals' denial of admitting privileges to non-physician health-care providers such as podiatrists, nurse practitioners, nurse midwives, and chiropractors); Comment, Hospital Privileges for Nurse MidWives: An Examination Under Antitrust Law, 33 Am. U.L. Rev. 959 (1984)(examining the denial of hospital privileges to nurse midwives under the current antitrust laws).

2. Bucar, Pharmaceutical Agents, 51 J. Am. Optometric A. 355 (1980). Practitioners, such as optometrists, feel that all diagnostic aids should be available for their use. This
oppose this increased participation on the grounds that non-medical professionals lack the proper training to provide such health care and that patients are unable to distinguish between the services offered by medical professionals and those offered by non-medical professionals. Two groups that epitomize this debate are the ophthalmologists, who are licensed physicians, and the optometrists, licensed health care professionals.

Dorland's Medical Dictionary defines ophthalmology as "that branch of medicine dealing with the eye, its anatomy, physiology, [and] pathology . . . ." In contrast, optometry concerns the "measurement of the powers of vision and the adaptation of lenses or prisms for the aid thereof, utilizing any means other than drugs." The very heart of the debate lies in the optometric professionals' attempt to literally re-define their field. While optometry may once have been defined as a "drugless" profession, lobbying efforts have caused state legislatures to allow optometrists a limited use of drugs. This use of drugs by optometrists has caused access would allow patients to "receive the benefit of complete diagnoses, treatment, and referral when necessary and at the least cost to the patient." Id. at 356.

3. DORLAND'S POCKET MEDICAL DICTIONARY 501 (23d ed. 1982).
4. Id. at 503.
5. A majority of states now allow optometrists the use of diagnostic drugs. See infra notes 11-13, 32-35 and accompanying text. This use is intended to facilitate the optometrist's diagnoses of eye problems which, prior to these statutes, was not within the realm of an optometrist's profession. PHYSICIAN'S DESK REFERENCE FOR OPTHALMOLOGY 2-16 (J. Walsh & A. Gold 16th ed. 1988)[hereinafter PHYSICIAN's DESK REFERENCE]. Diagnostic drugs fall within four broad categories: miotics, cycloplegics, mydriatics, and anesthetics. Id. at 2-10. Mydriatics and cycloplegics are topically applied drugs used for dilation and paralysis of the eye. "It is important to remember that the effect of . . . autonomic drugs . . . depends upon many factors such as the age of the patient, the color of his iris and his race." Id. at 2. Miotics are used for "the treatment of glaucoma." Id. at 3. Anesthetics "permit the clinician to perform ocular procedures such as tonometry, removal of foreign bodies from the surface of the eye, and . . . irrigation." Id. at 10. Significant visual and even life-threatening side effects are a concomitant threat with the use of these drugs. Id. at 2-16. A growing number of states now allow optometrists not only the use of diagnostic drugs but also the use of therapeutic drugs. See infra note 12. This development is a dramatic move from the traditional role of the optometrist. Prior to these statutes, optometrists were mainly responsible for the refraction of eyes and the prescription of glasses when necessary. If an optometrist discovered an abnormality of the eye during an examination, his duty of care was to recognize the problem and refer the patient to the appropriate physician or ophthalmologist. Classe, A Review of Professional Liability Cases Affecting the Practice of Optometry, 57 J. AM. OPTOMETRIC A. 66, 67 (1986). In those states which allow diagnostic and therapeutic drug use by optometrists, the clear implication is that an optometrist may diagnose a problem and treat the eye. See infra notes 113-18 and accompanying text. Therapeutic drugs fall into the categories of antimicrobial therapy, ocular anti-inflammatory therapy, and glaucoma therapy. PHYSICIAN'S DESK REFERENCE, supra, at 4-11. The antimicrobial drugs are used to treat infections caused by bacteria, fungus,
increasing alarm within the ophthalmology community. Ophthalmologists argue that the optometrists’ degree of pharmacological as well as generalized medical training does not adequately insure appropriate eye care, specifically in the areas of diagnosis and treatment. The ophthalmologists’ concerns range from possible dangers resulting from drug therapy complications to the inability of patients to differentiate between the services offered by an “eye care center” and a medical ophthalmologist.

Given the increased blurring of statutory boundaries between these two professions, the question arises as to how well the development of optometric drug use has actually aided patients in their search for quality eye care. This Note will address the issue of whether the current standard of care applied to optometrists effectively insures appropriate patient care, given the optometrists’ increased access to diagnostic and therapeutic drugs. Since optometry is no longer a “drugless” profession, a re-examination of the standards imposed on the field is necessary. If optometrists are moving into an area previously limited to the medical sub-specialty of ophthalmology, should optometrists be held to the same standard of care currently required of ophthalmologists in their diagnostic and treatment responsibilities? Currently, legislatures do not offer a solution to this problem. Each state, acting as a

and virus. Id. at 4. Clearly “[p]roper treatment of an ocular infection depends on determining the inciting agent.” Id. The area that concerns the ophthalmology community the most is the optometrists’ use of ocular anti-inflammatory drugs. These drugs, used to treat eye inflammations, must be closely monitored due to a variety of side effects; most notably “[t]opical corticosteroids can elevate intraocular pressure, and in susceptible individuals can induce glaucoma. They can also cause cataract formation . . . .” Id. at 9. In addition, ocular anti-inflammatory drugs, such as dexamethasone, can inhibit the immune system defense mechanisms and may predispose the patient to severe vision threatening bacterial and viral infections. Id. at 66.

6. J. BEGUN, PROFESSIONALISM AND THE PUBLIC INTEREST (1980). In an attempt to expand their professional status, optometrists began the push for expanded work boundaries. However, “[t]hese actions have sparked strong opposition from physicians, so much that some optometrists now regret the boundary expansion movement.” Id. at 34.

7. See infra notes 45-56 and accompanying text.

8. A good source for the services offered to the public by optometrists is the Ameritech Yellow Pages. Advertisements include the following services, “A modern, thorough Eyesight Analysis Program including checks for Glaucoma and Cataracts,” “complete optical service,” and “Caring Vision Care For The Entire Family.” AMERITECH PUBLISHING, INC., CLEVELAND CONSUMER YELLOW PAGES 922-24 (1988-1989).

9. See infra notes 57-68 and accompanying text.

10. See infra notes 23-39 and accompanying text.

11. The majority of the states allowing optometric diagnostic and therapeutic drug use do not address standard of care requirements. A notable exception occurs in Colorado’s statute: “A licensed optometrist who utilizes these pharmaceutical agents described in this
separate entity, determines the boundaries of optometric drug use.\textsuperscript{12} While the state statutes range from a prohibition on optometric drug use to full access to both diagnostic and therapeutic drugs, the trend is to loosen restrictions on optometrists without specifying a required standard of care.\textsuperscript{13}

In the past, courts have attempted to protect the interests of the patient by applying a stricter standard to the medical field when the existing professional standard failed to adequately protect the patient.\textsuperscript{14} As the boundaries of the medical profession

section for examination purposes shall be required to provide the same level and standard of care to his patients as the standard of care provided by an ophthalmologist utilizing the same pharmaceutical agents for examination purposes.” \textit{Colo. Rev. Stat.} § 12-40-102 (1985).

12. The following is a list indicating the current status of the fifty state legislatures on the issue of pharmaceutical use by optometrists.


13. \textit{Classe, The Right to Practice Primary Care}, 57 J. Am. Optometric A. 549, 550-51 (1986). Courts have not presumed that optometrists will endanger their patients. The statutes are seen by the optometry profession as a method of improving the scope of services offered to patients. \textit{Id.} at 551.

14. \textit{See infra} notes 127-33 and accompanying text.
continue to shift, the courts will have to consider what standard of care should be applied to a given case. Since the legislatures remain silent on the duty of care owed by optometrists to their patients, the courts must impose a standard of care consistent with the optometrists' increased access to diagnostic and therapeutic drugs.

A solution that will ensure the competent treatment of eye care patients is available to the courts: an optometrist who undertakes the use of drugs in diagnosis and treatment, must submit to the same standard of care required of an ophthalmologist. Optometrists are increasingly intruding into territory previously reserved for ophthalmologists. In order to ensure that patients will receive quality eye care, this Note will propose that optometrists be held to a duty of care which is commensurate with their developing capabilities. The courts must re-evaluate the current standard of care imposed on optometrists and raise the standard to reflect the optometrists' rising "specialist" status.

I. LEGISLATIVE DEVELOPMENT OF OPTOMETRIC DRUG USE

State legislatures have the authority to regulate the health and general welfare of the public. Licensing statutes place strict requirements on those who practice medicine. Accordingly, li-

15. Id.
16. See infra text accompanying notes 133-40.
17. See infra text accompanying notes 127-33.
18. See infra text accompanying notes 133-40.
19. State authority to regulate the health and welfare of its citizenry is an implied power left to the states under the tenth amendment to the United States Constitution: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST. amend. X.
20. Ohio's statute which regulates physicians and other practitioners is a good example of the detailed requirements of admission to practice medicine:
The applicant must . . . produce a diploma from a medical institution in the United States in good standing as defined by the board at the time the diploma was issued . . . [and] must produce satisfactory evidence to the board verifying the successful completion of not less than twelve months of post-doctoral training in an approved hospital in the United States . . . . Each applicant shall be examined in such subjects as the board requires. The board shall examine in subjects pertinent to current medical educational standards . . . . The board . . . shall . . . refuse . . . an applicant . . . for one or more of the following reasons: . . . failure to use reasonable care discrimination in the administration of drugs, . . . [w]illfully betraying a professional confidence, . . . [a] departure from, or the failure to conform to, minimum standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established, . . . [c]ommission of an act that constitutes a misde-
censing statutes specify the responsibilities of health care professionals, such as optometrists, who offer their services to the public.\textsuperscript{21} When any area of the health care field is serviced by both licensed physicians and licensed health care professionals, the issue of the quality of the health care being offered the patient will necessarily arise.\textsuperscript{22} This overlap in the health care field has occurred with the entrance of optometrists into the "medical" side of eye care.

One of the major developments in the field of optometry has been the emergence of statutes allowing optometrists access to prescription drugs for diagnosis and treatment.\textsuperscript{23} Historically, the optometric profession has been differentiated from the medical field through a legislative prohibition on all drug use.\textsuperscript{24} A number of states still maintain this traditional restriction on optometrists. Alabama, for example, provides that: "[n]othing in this section shall be construed so as to permit [an optometrist to administer] drugs in \textit{any form} or [to prescribe] drugs for the medical treatment of eye diseases or the performing of surgery of any nature for any purpose."\textsuperscript{25} These state provisions reflect the belief that the optometrist's role consists solely of refractions and the fitting and selling of glasses. Initially, legislative statutes prohibited op-

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  \item meanor . . . if the act involves moral turpitude, . . . [a]ny division of fees or charges . . .

\textbf{Ohio Rev. Code Ann. §§ 4731.09, .13, .22 (Baldwin 1987).}
\item 21. Ohio also carefully regulates non-physician health care fields such as optometry:
  No person shall engage in the practice of optometry . . . or hold himself out as a licensed optometrist when not so licensed . . . No optometrist shall administer topical ocular pharmaceutical agents unless he has passed the general and ocular pharmacology examination . . . Each person who desires to commence the practice of optometry shall file . . . a written application for the licensing examination . . . No person is eligible to take the licensing examination unless he [has] . . . graduated from a school of optometry accredited by the board . . .
  No person shall be permitted to take more than four licensing examinations . . .

\textbf{Ohio Rev. Code Ann. §§ 4725.02, .08, .09 (Baldwin 1987).}
\item 22. Gray, \textit{Podiatrists and Optometrists Mounting Provincial Lobby Campaigns to Get Greater Treatment Authority}, 119 \textit{Canadian Med. A. J.} 370 (1978). Optometrists and podiatrists are among the most vocal non-medical professional health groups who have sought to upgrade their professional status. Both groups have also lobbied for the use of prescription drugs in treatment. \textit{Id.}
\item 23. Classe, \textit{supra} note 13, at 549. The original optometric practice statutes were restrictive in barring optometrists from using pharmaceutics. In 1971, Rhode Island amended its optometric practice statutes to become the first state to allow the use of pharmaceutical agents by optometrists.
\item 25. \textbf{Ala. Code § 34-22-1 (1985)(emphasis added).}
tometrists from using any type of "drug," therefore a literal reading of these statutes even prohibited optometrists from dispensing contact lenses. Under the Food and Drug Administration's definition, soft contact lenses were considered a drug requiring pre-marketing approval.\textsuperscript{26} Optometrists, in an effort to expand their treatment potential, began to lobby for the legal right to prescribe contact lenses. This effort led to a confrontation with the ophthalmology profession.

The ophthalmologists' basic argument, reiterated years later in a variety of situations, was that contact lenses were a drug as defined by the Food and Drug Administration.\textsuperscript{27} Since state statutes specifically prohibit optometrists from prescribing any type of drug, optometrists, arguably, should not be allowed to prescribe contact lenses.\textsuperscript{28} In general, these legal confrontations revolved around the question of "what constitutes the practice of optometry?" and covered a number of issues ranging from the fitting of contact lenses to glaucoma screening by optometrists.\textsuperscript{29}

By the early 1970s, the discussion of increased primary care potential turned to the use of diagnostic drugs. Not only was the ophthalmology community concerned, but conflict was also noted within the optometric ranks: "In the past there were many well-intentioned, highly competent practitioners who felt strongly that the profession had little use for pharmaceutical agents for diagnostic purposes."\textsuperscript{30} However, an opposing perspective was voiced by many optometrists:

If some [optometrists] are diehards and refuse to admit the occasional superiority of cycloplegic refraction and the necessity of corneal tonometry, I wish that they would do me one favor: Please don't try to prevent me from bettering myself and my profession, and offering the public the best possible eye care that the state of the art will permit.\textsuperscript{31}

Despite some optometrists who had reservations, the optometric profession was successful in obtaining legislative approval for di-

\begin{footnotes}
\begin{itemize}
\item \textsuperscript{26} S. COBLENs, supra note 24, at 24. See also Winograd v. Johnson, 38 Colo. App. 432, 561 P.2d 1274 (1976) (Optometrists may prescribe and fit a soft contact lens which has been classified as a drug by the Federal Food and Drug Administration.).
\item \textsuperscript{27} Winograd, 38 Colo. App. at 433, 561 P.2d at 1275-76.
\item \textsuperscript{28} Id. at 433, 561 P.2d at 1276.
\item \textsuperscript{29} Classe, supra note 13, at 550.
\item \textsuperscript{30} Bucar, supra note 2, at 355.
\item \textsuperscript{31} Id. at 356 (quoting letter from Thomas H. McNaughton to the editor of the Optical Journal and Review of Optometry (June 1, 1962)).
\end{itemize}
\end{footnotes}
agnostic drug use in a majority of states.\textsuperscript{32}

Statutes providing for the use of pharmaceutical agents in diagnosis vary widely in the discretion allowed to the optometrist. Vermont, for example, allows optometrists the use of diagnostic drugs, but with specific limitations on the types of agents used in diagnosis and an absolute prohibition on the therapeutic use of drugs.\textsuperscript{33} These limitations are often detailed, specifying the types of diagnostic drugs available for use as well as limiting the allowable dosages and strengths.\textsuperscript{34} Other states, such as North Carolina, control optometric diagnostic drug use by requiring consultation with a "physician duly licensed to practice medicine."\textsuperscript{35}

Unappeased by its growing ability to diagnose problems with the aid of pharmaceuticals, optometry now seeks to expand its boundaries to include therapeutic drug use. While twenty-three states have extended the bounds of optometry to include diagnostic drugs, an additional twenty-two states have stretched the limits to include diagnostic and therapeutic drug use.\textsuperscript{36} For example, in Kentucky, "[t]he Board [of Optometric Examiners] may authorize only those persons who have qualified for use of diagnostic pharmaceutical agents . . . to utilize and prescribe topical thera-

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    \item \textsuperscript{32} See \textit{supra} note 12 and accompanying text. At the time when the optometric lobby was succeeding in its attempts at obtaining diagnostic drug use, the profession seemed to want to join forces with ophthalmologists and engage in "interprofessional" practice. The goal was to "practice . . . optometry in harmony with the practice of ophthalmology such that there exists equal professional responsibility . . . ." Edlow & Edmonds, \textit{Interprofessional Optometry}, 54 J. AM. OPTOMETRIC A. 1021, 1021 (1983). The ophthalmologists believed that, since optometrists were unable to diagnose and refer patients adequately by themselves, they needed the support of ophthalmologists. \textit{Id.} at 1022.
    \item \textsuperscript{33} VT. STAT. ANN. tit. 26, § 1723 (1987) provides that "[s]uch use [of diagnostic pharmaceutical agents] shall be for detection purposes only, and nothing in this subchapter shall be construed to permit the administering of drugs for the medical or therapeutic treatment of any disease . . . ." \textit{Id.}
    \item \textsuperscript{34} ILL. ANN. STAT. ch. 111, para. 3915 (Smith-Hurd Supp. 1988) provides as follows: "For the purposes of this Act, 'topical ocular pharmaceutical agents' means: (1) Proparacaine HCL (0.5%), (2) Benoxinate HCL (0.4%), (3) Tropicamide (0.5% and 1.0%), (4) Cyclopentolate (0.5% and 1.0%), (5) Atropine Sulfate (ointment) (0.5%), (6) Homatropine (2.0% and 5.0%), (7) Phenylephrine HCL (2.5%), (8) Hydroxyamphetamine Hydrobromide (1.0%) . . . ." \textit{Id.}
    \item \textsuperscript{35} N.C. GEN. STAT. § 90-114 (1986) reads as follows:
        Provided, however, in using or prescribing pharmaceutical agents, other than topical pharmaceutical agents within the definition hereinabove set out which are used for the purpose of examining the eye, the optometrist so using or prescribing shall \textit{communicate and collaborate} with a physician duly licensed to practice medicine in North Carolina . . . .
        \textit{Id.} (emphasis added).
    \item \textsuperscript{36} See \textit{supra} note 12 and accompanying text.
\end{itemize}
peutic agents in the examination or treatment of any condition of
the eye or its appendages." 37 This trend has been repeated in a
variety of states. 38

As the optometry field began to widen its parameters of diag-
nostic procedures and treatment, ophthalmologists started to voice
concern over quality-of-care issues. One of the ophthalmologists' main arguments focused on the different educational requirements
demanded of the two fields. They believed that the optometrists' training in pharmacology and medicine was inadequate to insure safe patient care when using therapeutic drugs. 39

II. QUALITY-OF-CARE CONCERNS DUE TO OPTOMETRIC DRUG
USE

A. Complications with Drug Therapy and Diagnosis

Prior to the enactment of various state statutes allowing
pharmaceutical drug use, the ophthalmology profession was con-
cerned with improper referrals by optometrists. In Ketcham v.
King County Medical Service Corp., 40 ophthalmologists testified
that thirty-five percent of the patients examined had some type of pathological problem potentially detectable by an ophthalmologist. 41 The professionals pointed out that a variety of eye diseases and disorders were detectable by examination. In addition, a large number of diseases and bodily conditions not commonly associated with the eye were also detectable. 42 A routine eye examination by an experienced diagnostician could reveal "brain tumors, arteriosclerosis, tuberculosis, diabetes, chorioretinitis, glaucoma, retinal detachment, iritis, retinal sarcoidosis, [and] fat embolic presence . . . all of which usually demand immediate medical treatment." 43 The ophthalmologists further testified that many of these problems would go undetected if the examinations were conducted

37. KY. REV. STAT. ANN. § 320.250 (Baldwin 1986).
38. See, e.g., FLA. STAT. ANN. § 463.055 (West 1987); N.C. GEN. STAT. § 90-114 (1986).
39. See infra notes 45-56 and accompanying text.
40. 81 Wash. 2d 565, 502 P.2d 1197 (1972). An ophthalmologist testified "that he regularly finds on an average of [sic] four or five patients a year suffering from pathological conditions whose eyes have been refracted by optometrists but who were not referred to ophthalmologists for eye care." Id. at 571, 502 P.2d at 1201.
41. Id. at 572, 502 P.2d at 1201.
42. Id. at 571, 502 P.2d at 1201.
43. Id. at 572, 502 P.2d at 1201.
The ophthalmologists' disquiet became more acute when optometrists were allowed to use and dispense prescription drugs. Their basic concern lays in the narrow pharmaceutical training received by optometrists.

No drug is always safe in all circumstances. One needs to know all the possible dangers, one must be aware of a preparation's potential systemic as well as local effect. This is why medical students not only spend at least 120 hours of their training on pharmacology, but also study in great depth the patho-physiology of disease so that they can cope with the complications of drug therapy.

Ophthalmologists felt that allowing optometrists to use prescription drugs, and specifically therapeutic drugs, was not in the best interests of the general public. While the side effects of these drugs may be "mild and of a transient nature," they may also occur with "consequences [that] can be horrendous."

Physicians believe that medical training is first a process of generalization and then one of specialization.

"[Y]ou must generalize before you specialize. The bulk of medicine is diagnosis; you can find the appropriate treatment in the textbook. The majority of training in medical school is aimed not at becoming a technician but at developing the skill of a diagnostician. Nobody but a conventionally trained MD has this skill for the whole body."

Medical education allows the physician to examine pathologic

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44. Id.
45. Gray, supra note 22, at 370. Physicians do not question that optometrists serve a useful and practical function in the eye-care area. However, they do feel strongly that only a "medical practitioner" has the training to diagnose. The advent of optometric drug use encroaches on the diagnostic area, thereby causing the conflict. Id.
46. Id.
49. Id. at 370. Gray further states that:
[U]nique in medical education is the way students are trained to examine any pathologic condition and evaluate possible therapy in the context of the whole body. Other groups . . . employ their skills when the patient's problem has been identified as being on their pitch, but the primary process of identification should be left to the people trained to do it: physicians.
Id. (quoting statement by Dr. Douglas Waugh).
50. Id. (quoting statement by Dr. John Bennett).
conditions and evaluate the problem in terms of the "whole body." By contrast, a field such as optometry is only looking at one particular organ and is unable to assess whether the eye problem is symptomatic of other more severe problems.\textsuperscript{61} "If an individual goes to an optometrist and he diagnoses cataracts, he won't be able to do all the tests — blood sugar, urine and so on — for diabetes . . . . Unless the optometrist sees fit to refer him on to a general practitioner, the results for the patient could be disastrous."\textsuperscript{62}

There is relatively little data on the problems encountered by optometrists in their use of diagnostic drugs. Articles produced at the time of the initial legislative changes concluded that side effects from diagnostic pharmaceuticals were low and that the benefits to patients outweighed any risks.\textsuperscript{63} However, in the case of therapeutic drugs, even ophthalmologists acknowledge a fertile area for mistake and mismanagement.\textsuperscript{64} In fact, one of the most frequent malpractice claims made against ophthalmologists arises from their use of pharmaceuticals.\textsuperscript{65} Within this particular group of claims, "[t]he most common drug implicated in the analysis of malpractice actions related to the use of ophthalmologicals is topical steroid;" the very drug available to a growing number of optometrists.\textsuperscript{66}

\section*{B. Patient Confusion}

Another concern among ophthalmologists is the belief that patients are not aware of the differences between optometrists and ophthalmologists. While the two fields are separated by educational requirements, degree of specialty training, and diagnostic and treatment options, patients are largely unaware of these distinctions. In \textit{Florida Medical Association v. Department of Professional Regulation},\textsuperscript{67} ophthalmologists brought a claim attempt-

\begin{itemize}
\item \textsuperscript{51} \textit{Id.}
\item \textsuperscript{52} \textit{Id.}
\item \textsuperscript{53} Yolton, Kandel & Yolton, \textit{supra} note 47, at 117.
\item \textsuperscript{54} Fox, \textit{Ophthalmology Practice and Tort Law}, \textit{CASE AND COM.}, Jan.-Feb. 1982, at 38, 42.
\item \textsuperscript{55} \textit{Id.} at 40.
\item \textsuperscript{56} \textit{Id.} at 42. Fox points out that malpractice claims involving miotics and topical steroids are among the most common. Problems tend to arise out of complications in the management regime and an "alleged failure to appropriately follow these patients for development of these complications." \textit{Id.}
\item \textsuperscript{57} 426 So. 2d 1112 (Fla. Dist. Ct. App. 1983).
\end{itemize}
The claim alleged that physicians had a duty to protect the public against harmful medical practices. In particular, the claim alleged that:

[the] general public has an imprecise and largely inaccurate understanding of the qualifications and training of optometrists and ophthalmologists, and, in effect, would be unable to make an informed decision concerning the qualifications of optometrists, as opposed to ophthalmologists, with respect to their need for certain kinds of eye care, all of which would result in injury to the public, and interfere with ophthalmologists' ability to properly render needed medical services.  

This type of patient confusion was also illustrated in the case of Fairchild v. Brian. A patient attempting to see an "eye doctor" was referred to an optometrist. Unaware of the possible differences in the title of "doctor," the patient was seen by an optometrist who ultimately failed to properly refer the patient to an ophthalmologist. The court pointed out that members of disciplines other than the medical profession are allowed to refer to themselves as "doctors." However, "the title should not be used under circumstances violative of the law, and in such a manner as to deceive or take advantage of others."  

A final point of potential confusion for the public lies in the variety of qualifications and certifications within the optometric field. Assuming that a patient does know the basic difference between optometrists and ophthalmologists, the array of certifications within the optometric field is very confusing. In Idaho, a state allowing optometric use of both diagnostic and therapeutic drugs, an optometrist, prior to 1988, could hold up to three differ-
ent types of certifications, each permitting the optometrist to employ different types of examinations and procedures. First, an optometrist must be licensed in the state. This license allows for "examining, testing, measuring, treating, correcting, developing, or improving the human visual apparatus." In order to use diagnostic pharmaceuticals in the examining procedure, the optometrist must, in addition to the license, be "the holder of a certificate for the use of diagnostic pharmaceutical agents." Finally, if the optometrist intends to "prescribe, administer and dispense . . . topically applied therapeutics" he must pass a special examination, be a holder of the diagnostic certificate, and complete an unspecified number of educational and clinical requirements. Today, all Idaho optometrists may use diagnostic pharmaceuticals and those with an additional certificate and examination may use therapeutics for treatment.

State legislatures have apparently ignored the concerns of the physicians and permitted varying degrees of pharmaceutical drug use in the optometric profession. Caught in the middle of this debate is the patient, who seeks both economical and quality eye care. Medical malpractice law, with its standard of care requirements, may be one line of defense for the medical services consumer.

III. STANDARD OF CARE

To define the standard of care required of professionals, courts look to the customary practices of the profession. This deference allows the given profession an opportunity to create the minimum standard to be met by its members. Generally, this standard is described as that degree of skill and learning maintained by members of the profession in good standing. This use

64. **Idaho Code** § 54-1501 (1987).
65. *Id.*
66. *Id.*
67. *Id.*
69. "The . . . effect of all of these rules has meant that the standard of conduct becomes one of 'good medical practice,' which is to say, what is customary and usual in the profession." W. *Keeton, Prosser and Keeton on the Law of Torts* § 32, at 189 (5th ed. 1984).
70. "It has been pointed out often enough that this gives the medical profession . . . the privilege . . . of setting their own legal standards of conduct, merely by adopting their own practices." *Id.* (footnote omitted).
71.
of custom as a negligence benchmark is frequently rationalized by the inability of the layman to understand and question the technical judgments of the professional. 72

Allowing a profession the ability to create its own professional standard of care alarms many jurists. Judge Learned Hand stated in the case of The T.J. Hooper 73 that a profession "never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission." 74 One such "imperative" directly affected the medical profession in the case of Helling v. Carey. 5 Despite extensive expert testimony showing that the defendant ophthalmologist had followed the standard of care as maintained by the profession, the Helling court held that it is the "duty of the courts to say what is required to protect patients." 76 Even though the professional standard is utilized as a factor in determining negligence, the courts have exerted their prerogative to ultimately rule on the minimum standard of a profession. 77

The formula under which this usually is put to the jury is that the doctor must have and use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing . . . [o]nly those in good professional standing are to be considered; and of these it is not the middle but the minimum common skill which is to be looked to [sic].

Id. at 187 (footnote omitted).

72. "Since juries composed of laymen are normally incompetent to pass judgment on questions of medical science or technique, it has been held in the great majority of malpractice cases that there can be no finding of negligence in the absence of expert testimony to support it." Id. at 188. See also Danzon, Medical Malpractice 16 (1985) (when applying the negligence standard to the practice of medicine, courts usually defer to the customary practice of the profession as established by expert testimony). See generally Brook, Brutoco & Williams, The Relationship Between Medical Malpractice and Quality of Care, in Medical Malpractice 19 (1977) (in evaluating whether the current malpractice system in the United States is adequate, one must carefully consider what quality of care standards are feasible, the relationship between quality of care and malpractice, and how best to study the malpractice system before legislating changes in it); Keeton, Medical Negligence — The Standard of Care, 10 Tex. Tech L. Rev. 351 (1979) (changes in the standards of care for physicians over the past twenty years have led to increasingly unpredictable liability for doctors, a liability which must be controlled through the adoption by doctors of national standards and through the use of expert medical testimony to aid juries).

73. 60 F.2d 737 (2d Cir. 1932) (owners of tugboats were held liable for sunk barges on the theory of negligence, despite the fact that the tugboat owners conformed to the standard of care in the tugboat industry).

74. Id. at 740.

75. 83 Wash. 2d 514, 519 P.2d 981 (1974).

76. Id. at 519, 519 P.2d at 983.

77. See infra notes 127-33 and accompanying text.
A. Standard of Care for the Ophthalmologist

The ophthalmologist is held to a higher standard of care than the general practitioner within the medical community. A professional whose work requires specialized training and knowledge is held to a standard of care commensurate with his superior skill. In *McPhee v. Reichel*, the court pointed out that in a malpractice claim against an ophthalmologist the appropriate standard of care is the "specialists' standard." An ophthalmologist acting within his specialty owes to his patient a higher standard of skill, learning and care than a general practitioner. He is expected to exercise that degree of skill, learning, and care normally possessed and exercised by the average physician who devotes special study and attention to the diagnosis and treatment of eye diseases. Due regard must of course be shown to the advanced state of the profession at the time of the diagnosis or treatment.

Not only is the ophthalmologist held to the specialists' standard of care, under some circumstances he may be liable to the patient for an even greater level of care. Through a series of malpractice claims against Washington ophthalmologists, the "reasonably prudent practitioner" standard emerged, requiring the ophthalmologist to exercise prudence in certain instances whether or not it is the general practice of the ophthalmology profession.

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78. "If the [physician] represents himself as having greater skill than this, as where the doctor holds himself out as a specialist, the standard is modified accordingly." W. Keeton, *supra* note 69, at 187 (footnote omitted).

79. *Id.*. See also Michaud & Hutton, *supra* note 63, at 722 ("[t]he duty of reasonable care requires those with special training and experience to adhere to a standard of conduct commensurate with such attributes"); Comment, *Standard of Care for Medical Specialists*, 16 *St. Louis U.L.J.* 497, 500-01 (1977)("with few exceptions, medical standard of care cases support the general proposition that a physician or surgeon who holds himself out as having special knowledge and skill in the treatment of some particular organ or disease must be held to . . . a higher standard of skill than a general practitioner"); Comment, *An Evaluation of Changes in the Medical Standard of Care*, 23 *Vand. L. Rev.* 729 (1970)(examining some of the existing court rules and their modifications pertaining to the medical standard of care).

80. 461 F.2d 947 (3d Cir. 1972).

81. *Id.* at 951. See also Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967)(court charged ophthalmologist with higher degree of skill and knowledge in the treatment of the eye than a physician with additional training).

82. *McPhee*, 461 F.2d at 951.

83. See generally Helling v. Carey, 83 Wash. 2d 514, 518-19, 519 P.2d 981, 983 (1974)(quoting Texas & Pac. Ry. v. Behymer, 189 U.S. 468, 470 (1903))("what is usually done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not ").
The heightened standard of care developed in this line of cases was affirmed in *Harris v. Robert C. Groth, Inc.* In *Harris*, a patient consulted an ophthalmologist for a recurring eye disease. The doctor prescribed "topical corticosteroids" without administering the intraocular pressure test indicated for a patient who is prescribed steroids. Despite continued use of the medication, the patient's condition worsened. Finally, she made an emergency visit to another ophthalmologist, who diagnosed acute glaucoma. The patient was rushed to the hospital where she underwent emergency eye surgery. The court examined the standard of care issue and determined that the "reasonably prudent practitioner" standard should apply. The court stated that the test in such a case is "whether a reasonably prudent ophthalmologist, possessing the degree of skill, care and learning possessed by other ophthalmologists in the state . . . , and acting in the same or similar circumstances . . . , would have performed an intraocular pressure test." In applying this "reasonably prudent practitioner" standard, the court declared that a practitioner's "[s]uperior knowledge, skill, or training" should always be taken into account.

B. Standard of Care for the Optometrist

While ophthalmologists are held to a standard of care associated with their specialized training, optometrists have traditionally been held to a standard of patient care consistent with the care and skill exercised by the optometric community. Prior to the various state statutes allowing optometrists an expanded role in eye treatment, the courts evaluated the optometrists' standard of care...
STANDARD OF EYE CARE

in light of the legislative restrictions placed on their profession. Since courts acknowledged the limitations on optometrists, malpractice issues often centered around the optometrist's failure to refer patients to an ophthalmologist when further testing, diagnosis, and treatment were required. The optometrist's role consisted of measuring visual acuity, performing refractions, and prescribing corrective lenses. In addition, the human eye was examined for any abnormality or manifestation of disease. Upon the discovery of any such problem, the optometrist was required to refer the patient to other health care professionals. Under this system, the optometrist's duties consisted of recognition and referral.

In Tempchin v. Sampson, a Maryland court measured an optometrist's actions by the standard of care exercised generally in the optometric community. At the time of the decision, the state legislature had defined the practice of optometry as "the employment of any means, except the use of drugs, medicine, or surgery . . . for the purpose of detecting diseased conditions." In Tempchin, the optometrist detected abnormalities in the eye but informed the patient that there was no need to consult an ophthalmologist. Deteriorating eyesight prompted the patient to seek the advice of an ophthalmologist, who diagnosed a medical problem which progressed to blindness. The ophthalmologist testified that if the optometrist had promptly referred the patient to him, then the patient's loss of eyesight could have been prevented.

89. Wills v. Klingenbeck, 455 So. 2d 806 (Ala. 1984)(the court looked to the customary practices of the optometry and ophthalmology professions and found that an optometrist has a duty to refer a patient to an ophthalmologist or neurosurgeon when eye disorders are discovered). See also Evers v. Buxbaum, 253 F.2d 356, 359 (D.C. Cir. 1958)("[a]s the consulted optician, [defendant] had undertaken an affirmative line of conduct, and throughout he was under an affirmative duty accordingly to take whatever precautions were reasonably required to protect [plaintiff] from negligence stemming from that conduct"); Steele v. United States, 463 F. Supp. 321 (D. Alaska 1978)(recovery allowed against United States for failure of U.S. Army optometrist to refer child to ophthalmologist upon observing disease in eye); Tempchin v. Sampson, 262 Md. 156, 159, 277 A.2d 67, 69 (1971)(optometrist "may and should detect disease but he may not treat it"); Fairchild v. Brian, 354 So. 2d 675 (La. Ct. App. 1977)(optometrist held negligent for not referring wife to ophthalmologist, which resulted in discovery of detached retina too late to save sight in the eye).

90. 262 Md. 156, 159, 277 A.2d 67, 69 (1971).  
91. Id. at 159, 277 A.2d at 69.  
92. Id. at 157, 277 A.2d at 68 (emphasis added)(quoting MD. HEALTH OCC. CODE ANN. § 10-101 (1986)).  
93. Id. at 158, 277 A.2d at 68.  
94. Id. at 158, 277 A.2d at 68-69.  
95. Id. at 159, 277 A.2d at 69.
The court determined that the liability of an optometrist is to be judged by "whether or not he did fail to exercise the amount of care, skill and diligence as [an optometrist] which is exercised generally in the community . . . in which he was practicing by [other practitioners] in the same field." \(^{96}\) The court concluded that this optometrist failed to refer a patient with a pathological condition for treatment, a violation of his duty and obligation as an optometrist.\(^{97}\)

The courts recognized that the prohibited use of diagnostic drugs handicapped an optometrist's ability to dilate the patient's eyes and obtain a full view of the peripheral areas.\(^{98}\) Given this recognized restriction, optometrists had the duty to refer a patient to an ophthalmologist when initial diagnosis indicated disease.\(^{99}\) A Louisiana court pointed out in *Fairchild v. Brian*\(^{100}\) that "expertise in the field of optometry bears no relevancy whatsoever to the practice of medicine. The law has been calculating in drawing a jurisdictional line between the areas of optometry and ophthalmology."\(^{101}\) The court found that after the optometrist diagnosed that his patient had an "early senile cataract" he proceeded to treat that disease.\(^{102}\) As a result, the patient was not referred to an ophthalmologist, the patient's eyes were never dilated, and the angioma that destroyed the patient's vision was not discovered until too late.\(^{103}\) The court held that the optometrist "transcended the bounds of optometry" by attempting to "diagnose and treat" a disease of the eye. Consequently, the optometrist was "subject to the same rules relating to the duty of care and liability as the

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\(^{96}\) *Id.* (quoting State v. Fishel, 228 Md. 189, 195 (Md. Ct. App. 1961)).

\(^{97}\) *Id.* at 160-61, 277 A.2d at 70. The duty to refer arose out of the prohibition against optometrists diagnosing or treating their patients.

Since an optometrist is not allowed to treat diseases of the eye, but only to correct refractive errors by means of exercises or corrective lenses, it has been observed that the reference of cases of possible eye pathology to a physician, generally an ophthalmologist, flows almost naturally. Both optometrists and opticians have an affirmative duty to refer patients in whom they discover pathological conditions . . .


\(^{99}\) *Id.* at 680.

\(^{100}\) 354 So. 2d 675 (La. Ct. App. 1978).

\(^{101}\) *Id.* at 679.

\(^{102}\) *Id.*

\(^{103}\) *Id.* at 680.
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C. The Move by Optometrists from Generalists to "Specialists"

Even after optometrists became able to use diagnostic drugs, the standard of care did not change dramatically. In a 1978 case, *Steele v. United States*, the court held that the optometrist had a duty to observe, although not diagnose, an eye disease and refer the patient to a qualified medical physician. The patient, an eight-year-old boy, was observed to have occasional crossing of the eyes. The boy saw an optometrist who diagnosed the problem as "esotropia," a condition potentially treatable with eyeglasses but also indicative of other serious medical problems. The optometrist prescribed eyeglasses but did not refer the boy to an ophthalmologist. A follow-up visit indicated that the patient's crossing of the eyes was occurring less frequently. However, based on a poor diagnostic reflex of the right eye, the optometrist prescribed another pair of eyeglasses. The boy continued to complain of an inability to see well, and was referred to an ophthalmologist who diagnosed a severe retinal inflammation. Unable to save the eye due to the extreme progression of the disease, the eye was enucleated. The court reaffirmed the principle requiring optometrists to refer their patients to medical doctors once disease is detected in the eye.

Upon detecting disease in the eye, it is then [the optometrist's] obligation and duty to the patient to make known what [he] 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.

While the standard of care demanded of optometrists who

104. *Id.* at 679.
106. *Id.* at 326.
107. *Id.* at 322.
108. *Id.*
109. *Id.* at 322-23.
110. *Id.* at 323.
111. *Id.* at 326. The court went on to state that the field of optometry was limited to discovery of disease and the area of diagnosis should be left to the medical physician. *Id.* at 330.
112. *Id.* at 326.
use diagnostic drugs still requires referral once eye disorders are suspected, the increased potential to recognize eye disease impacts on this standard. A South Carolina State Attorney General opinion addressed this issue when that state’s legislature considered a provision allowing optometrists to use diagnostic drugs. 113 The opinion stated that the use of diagnostic drugs would “necessarily expand the optometrist’s obligation to recognize eye disorders . . . which he should have noticed while using the specific drugs . . .”. 114 The opinion went on to say that “with the use of chemicals prior to his examination the patient of the optometrist should be thoroughly briefed as to [that] optometrist’s limitations as to diagnosis and to the discovery of eye disorders.” 115

These early cases and opinions turned on the fact that while optometrists were well qualified to refract and examine eyes as well as recognize a variety of eye abnormalities, their duty of care only extended to recognition of problems and referral to medical specialists. 116 This standard was based on legislative restrictions imposed on optometric diagnosis and treatment. 117

As optometrists continue to obtain greater diagnostic and treatment responsibilities, 118 they move from the role of the “drugless practitioner,” to one of eye care professional.

Courts have held that the status of “specialist” may be obtained by education and certification. 119 In addition, a specialist is frequently determined on the basis of his “holding himself out” to the public as an expert in a particular area. This is especially true if the physician treats a specific disease or a particular organ. In this regard, the optometrist has a duty to his patients to exercise a degree of skill and training of one who has devoted special study to a single organ of the body. 120 The question of specialist status is

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114. Id.
115. Id.
116. See supra notes 89-104 and accompanying text.
117. See supra note 12 and accompanying text.
118. See, e.g., N.C. GEN. STAT. § 90-114 (1986) which defines the responsibilities of optometrists as “the examination of the eye . . . to diagnose, to treat.”
119. Roberts v. Tardif, 417 A.2d 444, 452 (Me. 1980)(patients should have the right to expect a national standard of care when a physician holds himself out as a specialist due to certification and examination). See also Michaud & Hutton, supra note 63, at 733.
120. Reeg v. Shaughnessy, 570 F.2d 309, 315 (10th Cir. 1978). A physician is considered a specialist by a number of methods. The most common classification is on the basis of certification and education.

A specialist is: “A physician who confines his practice to specific diseases or disabilities. A physician who holds himself out as having special knowledge and
one of fact. For this reason, the manner in which the optometrist presents himself to the public as well as the public's perception as to the type and quality of care offered is critical in determining the appropriate standard of care to be applied.\footnote{121}

In the past, courts have acknowledged that optometrists are professionals with a duty of care limited to their capabilities as "drugless practitioners."\footnote{122} As their role as diagnosticians has expanded, due to increased access to diagnostic drugs, the courts have increased the optometrists' obligation to recognize eye disease and refer patients to an appropriate physician.\footnote{123} Now, as optometrists begin to obtain access to therapeutic drugs, the question arises as to what standard of care should be applicable to optometrists with "therapeutic" abilities.

The optometrists would argue that as a practitioner of a legislatively acknowledged "school" of medicine, they are held to the standard imposed on the general class of optometrists — the test of learning, skill, and care of the average optometrist.\footnote{124} "[A] person following one system or school of medicine cannot be expected

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\footnote{121}See also Michaud & Hutton, supra note 63, at 733.
\footnote{122}See also Coyne v. Cirilli, 45 Or. App. 177, 607 P.2d 1383 (1980)(a greater degree of skill is required of the specialist who holds himself out as having special knowledge and training).
\footnote{123}See supra notes 89-104 and accompanying text.
\footnote{124}See supra note 105-15 and accompanying text.

This is the classic argument used by other professions as well, specifically chiropractors and podiatrists. Each such school is a distinct branch of the healing arts with principles, techniques, methods, practices, and procedures unique to its school. Consequently, these separate schools are required to exercise the degree of care and skill ordinarily exercised by others within their particular school. See generally Dolan v. Galuzzo, 32 Ill. 900, 396 N.E.2d 13 (1979)(practitioner of a particular school of medicine is entitled to have his conduct tested by the standards of his school); Boudreaux v. Panger, 490 So. 2d 1083 (La. Ct. App. 1986)(chiropractor is required to exercise the degree of care and skill ordinarily exercised by other chiropractors in similar community); Creasy v. Hogan, 292 Or. 154, 637 P.2d 114 (1981)(podiatrists are held to that standard of care measured by the degree of skill and care required of an ordinary careful podiatrist in the community); Sutton v. Cook, 254 Or. 116, 458 P.2d 402 (1969)(a drugless healer is entitled to have his conduct in the treatment of his patients tested by the standards applicable to the school or system to which he belongs and not by the standards of the medical practice); Sheppard v. Firth, 215 Or. 268, 334 P.2d 190 (1959)(rule that a practitioner is entitled to have his treatment of his patients tested by the rules of the school to which he belongs applies to drugless practitioners).
by his patient to practice any other. . . .”125 However, if this reasoning is followed, the patient is subject to a profession that is establishing its own standard of care. Since the courts have held that ophthalmologists are measured against a specialized standard of care due to their advanced learning and skill, the courts should hold this new variety of optometrist to the same or a similar standard. Various statutes have already acknowledged the similarity between the fields of optometry and ophthalmology as the two begin to occupy similar areas of treatment. These legislative measures, in some cases, have held the optometrist to the “same level and standard of care” required of the ophthalmologist.126 In order for a patient to be adequately protected, the law should view an optometrist with access to diagnostic and therapeutic drugs as an eye care specialist and be held to the same or a similar standard of care required of the ophthalmologist.

IV. PROPOSAL

A. Power of the Courts to Impose Stricter Standards

The courts have the power to reconsider the standard of care applicable to medical practitioners if the standard has fallen below acceptable practices.127 The courts have exercised this prerogative in several cases against ophthalmologists. In Helling v. Carey,128 the court determined that the standard of the profession may be inadequate to protect a patient. In order to insure patient care, a physician may be held to a standard with a higher duty of care than that employed by the average practitioner in the class to which he belongs.129 While this ruling was thought to be “a unique case,” the determination was based on a need to protect

126. See, e.g., COLO. REV. STAT. § 12-40-102 (1986), providing that “[a] licensed optometrist who utilizes those pharmaceutical agents described in this section for examination purposes shall be required to provide the same level and standard of care to his patients as the standard of care provided by an ophthalmologist utilizing the same pharmaceutical agents for examination purposes.” Id.
129. Id. at 517, 519 P.2d at 982.
patients when the profession's standard became inadequate. This rationale was again echoed in *Gates v. Jensen*, when the court imposed the reasonable prudence test on physicians, thereby requiring a standard of care higher than the one exercised by the ophthalmology profession.

This series of cases broke with the principle that the standard of care maintained by the profession was also the standard used by the courts. While this type of precedent has only been used in ophthalmology cases, there is room for a broader application.

**B. Optometrists as Eye Specialists**

Courts must recognize that the field of optometry has evolved from a "drugless profession" to one that has received legislative approval, in many states, to use drugs for both diagnostic and treatment purposes. Despite a number of attempts by the ophthalmology profession, this trend is unlikely to change on the legislative front. Regardless of how the legislatures view the problem, ophthalmologists' concerns are real. Optometrists do have greater access to prescription drugs and they are attempting to diagnose and treat eye problems with the use of these drugs. In some situations, legislatures have attempted to balance this access by requiring optometrists to obtain additional certification or additional education in pharmacology. These requirements, how-

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130. *Id.*
132. *Id.* at 253, 595 P.2d at 921.
134. *See supra* note 12.
137. Kentucky and Florida are examples of states maintaining additional educational requirements. In Kentucky, "[t]he utilization or prescribing of topical therapeutic pharmaceutical agents shall be limited to those persons . . . who have earned . . . six (6) semester hours in a course . . . in general and ocular pathology and therapy . . . ." KY. REV. STAT. ANN. § 320.250 (Baldwin 1986). In Florida, "[t]he certified optometrists may administer and prescribe topical ocular pharmaceutical agents . . . with among other things . . .
ever, vary from state to state. Even within a state, these requirements will produce a group of individuals who all call themselves "optometrists," but may in fact, be licensed to perform widely different procedures. While patients have the ultimate right to choose their doctor, this selection is frequently made without knowledge of the diversity of qualifications and certifications required of the two professions.

In order to assure patients some degree of quality control, a strict standard of care, as applied to optometrists, may provide some protection. If optometrists are viewed by the courts as holding themselves out as eye care specialists, offering both diagnostic and treatment services, they must conform to the strict standard of care placed on specialists. As optometrists try to expand their diagnostic and treatment responsibilities, the courts should view the optometrist as one assuming a specialty status with the same obligations of patient care as ophthalmologists.

CONCLUSION

Until the middle 1970s, the practice of optometry was distinct from the practice of ophthalmology. This distinction was maintained by licensing statutes, educational requirements, and a separation of the services offered to the public. However, beginning in the late 1970s and continuing today, optometrists have expanded their services in diagnostic and treatment techniques. This trend is most evident by the optometrists' success in receiving legislative approval to utilize prescription drugs in diagnosis and treatment.


[139] See supra notes 57-67 and accompanying text. One answer to the dilemma of the "ignorant" patient potentially lies in the area of informed consent. The rise of patient autonomy has resulted in increased litigation in this area. This principle requires health care providers to supply sufficient information to the patient such that an informed, intelligent decision can be made. Disclosure includes available alternative treatments. Perhaps optometrists can be required to inform their patients of the alternative services available or to inform their patients of any limitations in the optometric field. See generally Nelson, Medical Malpractice and the Transformation in Health Care Delivery, 17 CUMB. L. REV. 313 (1987)(the importance of informed consent); Schultz, From Informed Clients to Patient Choice: A New Protected Interest, 95 YALE L.J. 219 (1985)(the importance of patient autonomy); Studer, The Doctrine of Informed Consent: Protecting the Patient's Right to Make Informed Health Care Decision, 48 MONT. L. REV. 85 (1987)(examination of the doctrine of informed consent).

[140] See supra notes 119-21 and accompanying text.
In order to protect health care consumers, the courts must hold optometrists to a standard of care comparable to the specialist standard required of ophthalmologists. Each holds himself out as an eye care specialist, and to the consumer, there may be little apparent difference in the available care. If optometrists intend to assume the responsibilities of eye care professionals, they must also be held to the standard of care required of an eye care specialist.

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