Illinois Society of Eye Physicians and Surgeons (ISEPS)
Advance Optometric Procedures Policy Recommendations
Illinois Collaborative Optometric/Ophthalmological Task Force
August 22, 2017

Overview

"In order to protect the public and provide quality care[1]," the General Assembly established the Illinois Collaborative Optometric/Ophthalmological Task Force to examine training standards in order to certify optometrists to provide "advanced optometric procedures." As directed in the statute, the Illinois Department of Financial and Professional Regulation has until January 1, 2018, to either propose rules or draft legislation that is consistent with the recommendations, as presented below, agreed to by the Task Force.[2] The Illinois Society of Eye Physicians and Surgeons (ISEPS) was delegated in the statute the responsibility of offering proposed standards no later than September 1, 2017.

As a member of the Task Force, ISEPS approached this task with the seriousness it deserves. We undertook efforts to become familiar with current optometric education, especially as it relates to any form of surgical training. We also examined the current educational standards for eye surgeons, including meeting with curriculum deans and ophthalmology department chairs at Chicago area medical schools.

In weighing the development of our recommendation to the task force, ISEPS leaders paid particular attention to whether there is a demonstrated need to alter or reduce the current educational standards, as well as the impact of doing so with respect to the safety of patients. Indeed, patient safety is the prime focus of our effort, underscored by the statute's language to "protect the public and provide for quality care."

Recommendations

Surgery Prohibition

The Optometric Practice Act contains an explicit prohibition of surgery. Throughout consideration of the recent sunset reauthorization of the Act and potential amendments, deleting this provision has not been part of the discussion. The General Assembly reaffirmed this prohibition as recently as 2016. We recommend that the judgment of the legislature remain unchanged and the prohibition be retained.

While the General Assembly has prohibited performing surgery by licensed optometrists, the term is not defined. With the possible addition of "advanced optometric procedures" to the Act, this leaves open to interpretation – or possibly misinterpretation – exactly what constitutes surgery. It is important that these parameters be clearly and fairly spelled out so that licensees have proper notice as to what is and is not allowed. Thus, the following definition of surgery should be included in the Optometry Practice Act:

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[1] *From 225 ILCS 80/15.2*

[2] *Note: Because of the exclusion of surgery in the current optometry practice act, we believe that enactment of these provisions by the General Assembly will be required since the Department lacks the statutory or Constitutional authority to rewrite an existing statute.*

> For the purposes of this (optometry practice) Act, "surgery" means any procedure employed to treat diseases or conditions of the human eye and adjoining tissues or structures, to correct refractive error, or to alter or enhance structures of the eye or adnexa for cosmetic purposes in which human tissue is cut, ablated, vaporized, punctured, burned, frozen or otherwise permanently altered or penetrated by instruments, laser, ultrasound, cryotherapy, electrocautery, chemical cautery, ionizing radiation or by other means, including placement and removal of sutures, transplanting or applying human or other tissue, and inserting an instrument into or placement of a device into a natural opening of the body. "Surgery" does not include removal of a superficial foreign body from the surface of the eye or adnexa; removal using a topical anesthetic of non-perforating foreign bodies from the conjunctiva, eyelid, or the cornea no deeper than the midstroma; use of a scanning laser for purely diagnostic purposes to create an image; dilation and irrigation of the lacrimal ducts; insertion and removal of lacrimal plugs; mechanical epilation of eyelashes; mechanical removal of damaged corneal epithelium without the use of laser; scraping of the cornea for culture; application of self-retaining amniotic membrane on the cornea; or removal of a broken suture with approval of the surgeon who placed the suture.

Advanced Optometric Procedures

Under the Act, an "advanced optometric procedure" would be those procedures described above which are specifically excepted from the definition of surgery, as well as any other procedure authorized under the Optometric Practice Act which does not fall under the surgery definition. Advanced optometric procedures may not include any procedure: (1) requiring the use of general anesthesia; (2) in which the globe of the eye or any of its adjoining structures (including the eyelids) is penetrated by any means; (3) involving use of a laser except as provided for in the preceding definition of surgery purely for diagnostic imaging; (4) involving removal of live epithelial tissue from the cornea; (5) removal of or disturbing any cancerous/neoplastic tissue; (6) involving injections in or around the structures of the eye; and (7) requiring placement or removal of sutures. Advanced Optometric Procedures may not be performed on any patient under 18 years of age.

Educational Standards

The Board of Optometry, under the auspices of the Illinois Department of Financial and Professional Regulation, should be responsible for determining the appropriate levels of training required for a licensed optometrist to perform any advanced optometric procedure taking into account the technical skills need, the knowledge to properly diagnose the condition requiring an advanced optometric procedure, and above all, safety of patients.

With respect to surgical procedures, ISEPS has carefully analyzed the requirements for adequately training an eye surgeon. The current standard adopted by the General Assembly – completion of medical school and residency in ophthalmology and licensure as a physician – has been demonstrated as the appropriate means of training individuals to safely diagnose conditions requiring surgical intervention, performing the operative procedure itself, managing any complications or unintended results, and caring for the patient until the healing process is completed. Deviation from this standard should be considered only when there is a compelling and demonstrated benefit to the public. Doing otherwise could put patients at unnecessary risk. Inquiries during the Task Force deliberation did not reveal any public need which would justify altering or reducing the current educational standards that apply to eye surgeons. Thus, no changes are proposed regarding training standards for eye surgeons.

Process and Discussion

With the inception of the Task Force, the representatives of ophthalmology and general medicine committed to examining a mechanism that could allow certain Illinois optometrists to obtain certification in order to perform "advanced optometric procedures" provided that they meet appropriate training and experience standards that assure patient safety. In developing these recommendations, ISEPS sought to document the current state of optometric education and training. ISEPS also examined the list of potential "advanced optometric procedures" that have been discussed previously, and then identified the gaps in knowledge that would need to be addressed in order to meet the patient safety concerns. By understanding the current education and experience for both optometry and ophthalmology, it is possible to at least estimate the extent of additional training that might be required to accommodate certification for additional optometric procedures. The current educational standard for those performing any form of surgery on the eye or surrounding structures – including so-called "minor" procedures that typically would be performed in the office – is completion of medical school plus four years of residency: one year of general medicine internship and three years in an accredited ophthalmology residency program or another specialty residency, such as plastic surgery or dermatology. Only physicians licensed to practice medicine in all its branches currently meet the state's training requirements to perform these surgeries.

Logic and common sense dictate that any pathway for optometrists to perform similar outpatient, office-based procedures would have to include similar training to develop adequate clinical judgment, the ability to identify appropriate candidates for intervention, to assess response to treatment, and to be able to address intra-operative and post-operative complications, as well as the operative procedure itself. These factors are just as essential as is gaining the skill to perform surgeries on the eye and surrounding structures. It does not make sense that some professionals performing the same procedures would be subject to lesser levels of training. Therefore, it is clear the current standards required of a physician cannot be compromised or watered down.

During ophthalmology residency, cognitive skills are developed over a long period of time by physician-residents in training under the mentorship of highly experienced faculty. A small student-faculty ratio is critical to this educational process. These skills cannot be achieved in a program that lasts a matter of hours or even months, or by merely observing others, especially absent the substantial base of competence gained through the intensive experience – didactic and clinical – in medical school.

General Comments and Conclusion

It has been noted during the deliberation of the Task Force and during prior discussions that there is a clear difference in the approach to education and training for optometrists and physicians. Optometric education relies more on classroom instruction and observation[3] rather than hands-on clinical experience treating live patients with actual disease. Optometry is not a surgical profession; indeed, surgery has been specifically excluded by the General Assembly in the Illinois Optometry Practice Act as recently as 2016.

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[3] *This observation was made by optometry representatives both during the Task Force deliberations and earlier during informal discussions between the optometry and ophthalmology associations.*

Short of the proper medical school foundation, hospital internship, and surgical residency in ophthalmology, one cannot sufficiently become proficient in safely performing surgery on or around the eyes of a patient. Training of physicians – and particularly surgeons – is a rigorous, lengthy and intensive process of at least eight years after earning an undergraduate degree. It involves years of hands-on clinical experience (as well as additional didactic education after medical school) with many thousands of patients. An ophthalmology resident is the primary physician – under supervision – for at least 3,000 outpatient encounters. Although ACGME's[4] minimum requirements are that the resident performs at least several hundred surgeries during training, most residency programs exceed these numbers. As revealed during the Task Force deliberations, the number and setting for patient encounters in optometry school is substantially less. Indeed, a "residency" is not required for optometry students.

The names of these two professions are similar, to be sure, and we recognize they work together regularly as part of the eye care team. However, patients often do not know the difference between ophthalmologists and optometrists, and because of this, it is the responsibility of state regulators to assure the public that a health care professional permitted to do eye surgery is properly trained with demonstrated competence through the licensure process.

Differences in training cannot be ignored. As physicians, ophthalmologists are trained in a fundamentally different manner from optometrists. Board-certified ophthalmologists are required to: 1) attend four years of medical school (after earning an undergraduate degree) involving intense didactic education and clinical rotations; 2) attend a rigorous internship year diagnosing and treating a wide spectrum of disease and medical conditions; 3) train for at least three years under the supervision of academic ophthalmologists in a residency program; and 4) pass a strict board certification examination under the supervision of the independent American Board of Ophthalmology. Many ophthalmologists also train in one- or two-year fellowship programs, designed to further specialize in the care of diseases. By contrast, an optometrist does not attend medical school and is not required to complete any kind of residency program where competence is gained in managing patients with potentially serious diseases. While optometry schools do a good job training optometrists, they *do not* produce physicians/surgeons.

"Lesser" procedures do not require "lesser" training. Although a layperson may consider certain surgeries to be "minor" and, therefore, of lesser intensity than for example, a cataract operation, this may demonstrate a lack of appreciation concerning the basics of surgery, as well as the risks and benefits for every surgery initiated. Surgery to remove a benign-appearing skin tag may seem to be a "simple" procedure. Putting aside the potential for a complication such as significant bleeding, scarring, or disfigurement, substantial concerns are present before any cutting occurs. The correct diagnosis is imperative because what might appear to be a "simple" skin tag or a chalazion could well be a cancerous tumor which, if disturbed and/or not completely and correctly removed, can result in major health concerns (including death) for the patient. Practitioners with less clinical experience can be deceived by the presentation which actually could be a deadly melanoma or a sebaceous cell carcinoma.

[4] *ACGME is the Accreditation Council for Graduate Medical Education. The ACGME accredits Sponsoring Institutions and residency and fellowship programs, confers recognition on additional program formats or components, and dedicates resources to initiatives addressing areas of import in graduate medical education. ACGME currently accredits 116 ophthalmology residency programs representing 1,452 residents in training nationwide.*

Training of competent surgeons goes well beyond learning the manual dexterity of surgery. This cannot be achieved without learning the fundamentals of disease processes which is the foundation of medical school and an ophthalmology residency program. Exposure to sufficient numbers of actual patients with disease is mandatory in order to gain the proficiency that safeguards patient safety. This cannot be achieved solely through lectures, text books, videos, practicing on models, or observing others over a relatively short period of time.

ISEPS participated in the Task Force with an open mind and with the primary objective of preserving the highest standards of patient safety, and assuring that the citizens of Illinois would continue to receive quality surgical eye care. Any optometrists who wish to perform surgery certainly should be allowed to do so *when they receive proper training*. That training program exists now: it involves a four-year program of study at a medical school and a four-year residency program at a qualified institution (including the internship year). One cannot reasonably develop a "quickie" training program that teaches optometrists how to practice medicine/surgery. In the end, handling medical/surgical procedures requires tens of thousands of hours of training and experience. It cannot be bottled, distilled or easily transferred. A great paralegal cannot become a competent lawyer without going to law school, nor would the pilot of a single-engine propeller airplane be allowed to take the controls of a cross-country commercial jet. Similarly it is our hope that the members of the Task Force understand that a great optometrist cannot safely perform surgery without going to medical school and completion of an ophthalmic residency program.

As revealed during discussions at Task Force meetings and in subsequent investigation, ophthalmologists see, on average, approximately 20,000 patients during the course of their training. Optometrists see, on average, approximately 2,000 – or 90 percent fewer patients than an ophthalmologist in training. Optometrists who opt not to do an optional residency see even fewer patients. Ophthalmology residents mostly see patients with eye diseases disorders. Optometrists generally see healthier eyes in their clinical periods.

It must be noted that no data was presented to the Task Force that documented a lack of patient access in Illinois for any surgical procedure to any level of significance. We are not aware of any significant problem in the state for access to any ocular surgical procedure, and no evidence was presented to that effect. Therefore, changing the current standards for any procedures must weigh heavily in favor of patient safety protections.

Therefore, taking all of these critical factors into account, we recommend the following:

- Maintain current Illinois statute language that prohibits optometrists from preforming ophthalmic surgery
- Propose clarifying optometric statutory language to clearly define what constitutes ophthalmic surgery; and
- Add statutory language which defines "advanced optometric procedures," which are within an optometrist's scope of practice authority and not prohibited under the definition of surgery. The Board of Optometry would be responsible for proposing by rule what these specific procedures are and the corresponding training standards.