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DIPLOMATE AMERICAN BOARD OF OPHTHALMOLOGY

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Connecticut Public Health Committee

To Whom It May Concern:

I am writing this letter with some comments concerning the upcoming bill HB7159 in the state of Connecticut. I am a practicing ophthalmologist who has been licensed in the state of New York since 2001. Over the course of my career and prior to being licensed when I was in residency, I have had opportunity to work with many optometrists as well as other ophthalmologists. This exposure has allowed me to see a gradual increase in my continuum of care between the two specialties. During my career in many states, there has been an expansion of scope of practice for optometry. This has included among other things, the prescribing of antibiotic eyedrops, glaucoma eyedrops, and in some states including Connecticut, oral medications for the care of varied diseases. With regards to the specifics of the upcoming bill, it is my opinion as a practicing ophthalmologist that an intraocular pressure of 35 is an arbitrary level which does not really delineate a more endangered glaucoma patient vs. a more straight forward glaucoma patient. This alone would lead me to believe that inclusion of this arbitrary number, does not make much sense. It is my opinion that whether a doctor of optometry or a medical doctor of ophthalmology has a patient with glaucoma, that there are multiple factors that should be considered during treatment. If the patient, regardless of the presenting symptoms appears to be worsening despite their physician or optometrist's best efforts, then a prompt referral to a glaucoma sub-specialist should follow. I believe this should be the case whether the provider is an ophthalmologist or optometrist. Regarding the potential use of chronic oral medications for glaucoma treatment, currently the overwhelming majority of therapeutic treatment for glaucoma is done with topical eyedrops. There are a few oral medications that are typically reserved for only the most severely affected glaucoma patients who do not respond well to the topical treatments. However, on the horizon lie several oral medications that would be more targeted to glaucoma treatment and some of these medications may very well become mainstream glaucoma therapy for a large number of patients in the future. Certainly, in many instances, oral medications harbor the chance of increased systemic side effects. As a practicing ophthalmologist, there are treatments that I am allowed under my license to prescribe that I do not choose to, but instead allow sub-specialists to prescribe as they are more comfortable handling the potential side effects of these potent medications. However, there are many oral treatments that I do choose to employ. In the state of Connecticut, optometrists already carry the ability to prescribe oral antibiotics and in fact narcotics. I would simply state that if the newer medications that surface for oral treatment of glaucoma are felt to carry a similar risk profile to narcotic drugs or oral antibiotics, that I cannot see any reason why prescribing the oral glaucoma drugs should be any different.

I hope this letter is helpful in providing some insight into the opinion of at least one ophthalmologist who interacts with many optometrists on a daily basis in providing eyecare for a large number of patients in our community in upstate New York.

Sincerely yours,


David F. Westfall, M.D.