

Good afternoon. My name is Jessica McNally, and I am an ophthalmologist and current president of the Vermont Ophthalmological Society.

Thank you for allowing me to testify on behalf of Vermont Ophthalmologists to voice our concerns about the 2023 Office of Professional Regulation report on optometry scope of practice.

The singular goal of the Vermont Ophthalmological Society (VOS) is to ensure that Vermonters receive safe, high-quality procedural and surgical eye care. With that in mind, we have grave concerns about the conclusions of OPR's revised report.

The difference between an ophthalmologist and an optometrist is not well understood.- In fact, a 2018 survey conducted by the American Medical Association found that over half of respondents either did not know or were not sure if an optometrist was a physician (a medical doctor or surgeon). All ophthalmologists are physicians and surgeons. Ophthalmologists complete a four-year undergraduate bachelor's degree program after which they complete four years of medical school identical to other physicians and surgeons. After completing medical school, ophthalmologists move on to obtain 4-6 more years of residency and fellowship training. The first year of training can focus on general surgery, internal medicine, or a year that is a mix of general medicine, in-patient and out-patient care, emergency medicine, critical care and medical electives. Then residents complete three more years of focused training on advanced medical disease and surgery of the eye. The three year ophthalmology residency is standardized in all programs across the country and must meet rigorous, national Accreditation Council for Graduate Medical Education requirements (ACGME) (<https://www.acgme.org/specialties/ophthalmology/program-requirements-and-faqs-and-applications/>). The majority of ophthalmology trainees follow up their residency with another 1-2 year fellowship in a subspecialty such as Cornea, Retina, or Glaucoma, thus giving them more surgical experience.

The 4-6 years of ophthalmology residency and fellowship training are intense years comprised of hundreds of hours of hands-on surgical experience overseen by highly skilled mentor surgeons with years of training under their belts. As in all surgical residencies, Ophthalmologists are held to the highest standard of care and do not graduate from their program until they have proven competency not simply by numbers of surgeries performed, but most importantly by the observation of our mentor surgeons.

According to the Board of Medical Practice position statement on S. 233, *“Over the span of medical school and residency, when it comes to doing procedures on humans, the education and training follows a “crawl, walk, run” progression.... Over the ensuing years, to complete residency, ophthalmologists must document successful performance of an array of procedures over and over again, all in a setting where they are supported by experienced ophthalmologists who are available to ensure patients receive the care they deserve. It is only through this wealth of practical experience, all the time benefiting from the guidance and*

feedback of more experienced physicians, that an ophthalmologist develops the knowledge base, practiced hand, and confidence to attain the level of expertise that patients deserve.”

Optometrists also complete a four-year undergraduate bachelor’s degree program. They then attend a four-year optometric program and have the option of completing one year of additional training after that. This additional training is not required to obtain a Doctor of Optometry degree. In the materials provided by the optometrists in the OPR report, examples of such additional training are given including low vision, contact lenses, and ocular disease. What we (and what OPR) found is that in four-year optometric programs there are didactics (for example lectures and videos), along with the opportunity to perform simulations of the requested surgeries on model eyes and model skin. The standardization of numbers of hours of didactics and numbers of simulations performed is not clear to us from one optometry program to another. What is clear, and what OPR has found, is that in the far majority of optometry programs there is little to no hands-on surgical training on live human beings. What is also clear is that there does not exist any standardized program dedicated to eye surgery after graduating from optometry school. Therefore, we can conclude that appropriate standardized surgical training for optometrists does not exist in optometric education.

The two main arguments that VT optometrists have brought forward since beginning their effort to expand scope involve access and cost. Optometrists in Vermont have repeatedly asserted that by scope expansion access to these procedures will be improved. In Vermont we are extremely fortunate in that we have enough ophthalmologists to provide all scalpel and laser surgical care in and around the eye. It has been suggested that the absolute numbers of ophthalmologists in VT does not reflect access because some of us subspecialize and don’t perform these surgeries. The fact is that there are only a handful of ophthalmologists (typically Retina specialists) who don’t perform these surgeries. All other subspecialties and comprehensive ophthalmologists perform them, and those are well distributed throughout the state. Furthermore, a July 2023 article published in the Journal of the American Medical Association showed that in Oklahoma, Kentucky, Louisiana, Arkansas, and Missouri, scope expansion to include laser surgeries did not lead to shorter travel time or improved access. And we continue to have concerns that the primary eye care needs of Vermonters are not being met. According to OPR’s website, there have been 26 newly licensed optometrists in Vermont in the last 6 years. And yet anyone who has tried to get an eye exam lately by their optometrist knows that it is often a several months’ wait. It is difficult to understand how expanding the workload of an already busy optometric provider to include in-office surgeries could possibly improve access to primary eye care.

Indeed, the 2023 report from OPR concludes that “OPR is unable to determine whether expanding the optometric scope of practice would improve patient access to care. [pg. 31]”.

I can assure the Committee that if a Vermont patient needs expedited or urgent eye surgery, our optometrists know that they can reach out to us directly. In fact, many of us have each other’s personal phone numbers and e-mail addresses.

With regards to cost, many arguments have been put forward by Optometry insisting that scope expansion will decrease cost, for example the idea that a patient could simply be brought to another room on the day of diagnosis and have the surgery done right then and there. Optometrists argue that this would decrease cost by saving patients a trip to see a surgeon for another evaluation. This argument does not hold water. All ophthalmologists can cite examples of patients who were sent to them for the surgeries in OPR's report that, after being evaluated, were deemed not necessary. This in fact decreases cost by avoiding a surgery. Furthermore, it is nearly impossible to perform surgery on the same day of a patient evaluation because of complicated reimbursement issues and obtaining the required prior authorizations.

The 2023 report from OPR invalidates Optometry's claims by stating "OPR cannot determine the impact expansion of the optometric scope of practice would have on costs. [pg. 34]".

The VOS and Vermont Medical Society do not support the striking optometric scope expansion suggested in the report. We felt it important to participate in the review process with OPR to clarify language and provide input in the name of patient safety, but it has become clear that Vermont optometrists and the Vermont Board of Optometry do not recognize or acknowledge the gravity of the surgeries they seek to provide.

Optometrists have repeatedly portrayed ophthalmic lasers as "safe" and "easy". VOS firmly disagrees with this characterization. Ophthalmic lasers, as proposed for use inside the eye, are categorically surgical instruments used for altering tissue. Surgical treatment with ophthalmic lasers is not a primary eyecare service and should be performed by physicians and hospital residency-trained surgeons. I'm pausing here because there was a recent situation that illustrates the danger of lasers and the potential implications of their use in a setting of incorrect diagnosis. Just last week a Vermont optometrist made a diagnosis for which the treatment would have been a laser included in OPR's report. With an advanced procedure license this laser could have been performed by the optometrist in their office. The patient was referred to an ophthalmologist where a much more severe condition was diagnosed. A laser treatment by the optometrist would have been completely ineffective and could have caused further significant complications. Additionally, it would have added cost, and delayed diagnosis of a severe infectious disease that threatened the patient's and the community's health. This type of misdiagnosis leading to harmful use of laser surgery could be devastating. Furthermore, The existing and future laser eye care needs of Vermonters do not come close to providing the procedural caseload numbers needed for optometrists to maintain competency of the proposed laser procedures. The volumes of the lasers being performed by Vermont ophthalmologists are far from resulting in a back log.

Optometry scope expansion into the scalpel and injection surgeries listed in the report would allow optometrists to remove lesions (what some refer to as "lumps and bumps") on the eyelids and around the eye "evaluated by the optometrist to be non-malignant" as stated in OPR's report. The Oculoplastics specialist at UVM, Dr. Libby Houle, has spoken and written at length about how difficult it is to predict a malignant from nonmalignant lesion and how that even she, an expert, has been surprised. Other challenges in removing lesions from the eyelids

involve what happens to the skin after the removal, how the wound is often much larger than expected once the lesion is cut off. There can be unexpected excessive bleeding that can be anxiety provoking for the surgeon and the awake patient. The OPR report would allow repairs of traumatic eyelid lacerations if they are a certain depth and length. Eyelid lacerations of any size need to be numbed up and thoroughly explored before that depth can even be determined, much less sutured. Other procedures in the OPR report include corneal crosslinking which requires fellowship training beyond the standard ophthalmology residency. In fact, this procedure is outside the scope of practice of all VT ophthalmologists, including myself, except for one Cornea specialist who has the appropriate training. Our Retina surgeons have significant concerns about the inclusion of fluorescein angiography on the list. This is an in-office dye test to look at structures in the back of the eye. The dye is injected into a vein, often causing nausea and sometimes vomiting and potentially anaphylaxis. Our Retina specialists maintain that the far majority of retina disease can be diagnosed with other equipment that is already widely available and utilized regularly in almost every optometrist's office in the state. It is unclear to us why optometrists would need to use fluorescein angiography when they do not provide, and have actually excluded, retina surgery in the OPR report.

According to the position of the Vermont Board of Medical Practice, *“One indicator of the complexity of these procedures and the high stakes for the patient is that among physicians, only ophthalmologists do them. General surgeons do not do eye procedures. Primary care and emergency physicians do not do eye procedures. They all defer to ophthalmologists, treating only basic eye issues or providing only care that is necessary until ophthalmologic care is available.”*

Even after hearing all our concerns about training, risk to patient safety, and finding that there would be no increase in access or cost savings, OPR concluded that it “supports expanding the optometric scope of practice to include the proposed advanced procedures so long as optometrists have the training necessary to perform the procedures safely on human patients”.

So, the question then becomes, who decides what that necessary training is? Is it OPR? Is it the legislature?

What OPR has been unfairly tasked to do by the legislature is to create some sort of compromise that will make some feel better about a bill being passed. They have done hours of research into this issue, held public meetings, had lengthy meetings with stakeholders, and taken comments from the public. Then, with this information, they have created a surgical training program for optometrists, which they have labeled a preceptorship. Clearly, OPR does not find that current optometric education provides the necessary training to perform these surgeries. If they did, they would not feel it necessary to be-creating a surgical training program.

We have the utmost respect for OPR and for the work they have done on this issue, but they do not have the expertise to make recommendations on what type of training is required to safely perform eye surgery. When we asked them in one of our meetings, how can you possibly know in any detail about all the professions you oversee, the answer was “we depend on experts”. OPR’s proposal to bolster training experience, while admirable, falls far short of ensuring safe eye surgery in Vermont. Setting appropriate standards for medical and surgical training should only be done by a properly accredited organization. This organization should be comprised of individuals with firsthand knowledge and expertise in eye surgery and developing curricula in a proven standardized fashion to ensure competency of surgeons and accountability of the accrediting body. Safe eye surgery for Vermonters can only be provided by physicians who have completed medical school and an ACGME accredited Ophthalmology residency program.

As found by the Board of Medical Practice, “Patients should not be put in the position of making the choice to accept care from a provider who has so much less training and expertise doing the procedures at issue. The public counts on government, relying on the expertise of those who have the knowledge and understanding to assess the risks, to make appropriate decisions on matters such as this.”

I will close with where I began, the singular goal of the Vermont Ophthalmological Society (VOS) is to ensure that Vermonters receive safe, high-quality procedural and surgical eye care. As legislators, your ultimate responsibility is to protect the safety and wellbeing of the people of Vermont.

With something as precious as our eyes, why would we take unnecessary risks?

Respectfully submitted,

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