Testimony Regarding H 104, S 9, C 30

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Members of the committee,

Thank you for including my testimony. I've been a medical doctor in Vermont for nearly a decade. I began in 2009, working for three years at a private practice in South Burlington. Next I trained for a year in Boston, studying medical and surgical treatment of glaucoma. Since 2014, I've been as an assistant professor of surgery at the University of Vermont Medical Center. I see patients from across Vermont and upstate New York. I'm also a professional educator. I have a master's degree in history, and prior to medical school, spent almost a decade teaching middle and high school history. Currently I teach medical students at the University and am the director of ophthalmic education for the department of surgery.

It is expected that the optometry guidelines, if made into law, would initially result in the widespread use of lasers, by optometrists, for treatment of glaucoma. The optometrists gave a statement to this effect, and this has been the pattern in places like Oklahoma. The committee received documents pertaining to controversy, in Oklahoma, resulting from optometric laser surgery. The study in Oklahoma showed failure to follow surgical standards of care and un-necessary repeat surgeries. I perform hundreds of glaucoma laser surgeries annually; thus I will center my comments here.

I will focus on three concerns: number one, access to care; number two, education; number three, safety.

First, regarding access, we are a rural state, yet we have approximately 5 ophthalmologists per 100,000 residents, which is exactly the national per capita average. Fully 80% of Vermont citizens live within 30 minutes of a Vermont ophthalmology office, and 100% live within an hour of a Vermont ophthalmologist. If we include the clinic at Dartmouth Medical Center, these numbers fall even further. At the University of Vermont, the wait time to schedule any glaucoma laser is zero days. Any patient or health care provider, and any optometry office, can reach me or one of my colleagues directly, by phone, at any hour of any day, during the week and on weekends, and on every holiday. Any patient requiring urgent care is seen and treated immediately. In the case of glaucoma lasers, the reality is that treatment generally is important but not urgent. Thus, a typical referral is seen within days to weeks. But please hear my emphasis: the wait time for glaucoma laser treatment in Vermont is zero days. There is no difficulty of access to care.

Second, regarding education, some of my colleagues have outlined the stark differences in the training of optometry on one hand, and the training of medical school, surgical residency, and fellowship

specialization on the other hand. I respectfully request that you consider this point very carefully. Optometrists are referred to as “eye doctors” but they are NOT medical doctors. They have no training in a medical school and no surgical training.

The proposed plan for optometric training is exceptionally vague. The only oversight is a board of optometrists, again specifically excluding medically trained professionals. An optometrist would be permitted to perform eye surgery following a short classroom course, instructional videos, and observation of a surgery. Actual supervised training upon real human beings is not included. This proposal ignores the central tenet of medical education, in America and worldwide, since the turn of the twentieth century. Namely, it ignores the fact that education begins over textbooks in the classroom, but is never complete without the rigorous study of actual disease, actual surgery, and actual human beings, in the clinic, in the hospital, in the surgical ward, and even upon dissection in the morgue.

In describing educational differences, I emphasize my conviction that optometry is an entirely honorable field, populated by good and hard-working people. Optometrists contribute valuably. Their skills in the complex art of measuring for eyeglasses and contact lenses vastly exceed my own. But all of us in life—whether we are medical doctors or doctors of optometry, electricians or plumbers, airline pilots or boat captains—we all are bound by the limits of our training and our knowledge. When we exceed our education, we begin making mistakes. In surgical care, the consequences and costs of erroneous diagnoses and flawed treatments are enormous, even life-threatening.

This connects to my third and most important point: patient safety. I want to share the story of three patients. I have changed names for confidentiality.

First is John, a five month old boy from Chateaugay, New York. John was followed for almost a month with red eyes. It was believed that he had a viral infection, the so-called “pink eye.” When the symptoms persisted, his mother brought him to Dr Sujata Singh, the pediatric ophthalmologist at the University of Vermont. Through examination, Dr Singh determined that A) he did not have pink eye and B) he had bilateral congenital glaucoma which, if untreated, would progress to blindness. This little boy required multiple incisional surgeries.

Second is Mary, a 74-year old woman from Waterbury, Vermont. Mary developed double vision. She was given eyeglasses which, through use of prisms, eliminated the doubleness. When the problem worsened, Mary came to see Dr Elizabeth Houle, an ophthalmologist at the University of Vermont. Rather than prescribe glasses, Dr Houle asked the fundamental question: Why did Mary develop double vision? Through examination and testing, she found that the problem stemmed from thyroid disease, a systemic disorder requiring systemic treatment to stabilize Mary’s overall health.

Last is Edward, a 42-year old man from Lyndon Center, Vermont. He had been having headaches and vision changes, and was believed to be suffering from glaucoma. After nine months of unsuccessful treatment, he was referred to UVM. Through examination, I could see that A) he certainly did not have glaucoma and B) he probably had a brain tumor. An MRI scan confirmed the brain tumor. He required multiple surgeries, in Vermont and Boston, with permanent vision loss and lifetime disability.

All of these patients had their initial evaluation and treatment from optometrists. In each case, the optometrist pursued a dangerously mistaken diagnosis and prescribed treatment that allowed the patient's disease to worsen. My colleagues and I made the correct diagnoses not because we are super-human, not because we are more talented, and certainly not because we are more professional people than the optometrists. We made these diagnoses because the training of a medical degree—the rigorous exposure to pathology in the eye and throughout the body—leads us to a wider sense of suspicion and to practice broader methods of investigation. These are three cases out of many, many that come from optometrists who have made wrong diagnoses and pursued erroneous treatments.

To briefly review my statement: First, there is no difficulty of access to care. Vermont has five ophthalmologists per 100,000 residents, exactly the national per capita average, and the wait time for glaucoma laser treatment in Vermont is zero days. Second, the proposed optometry guidelines provide no meaningful educational pathway; they fail to provide actual training in real life surgery, which is the essential and most challenging portion of any surgeon's education. And last, please carefully consider the ramifications to patient safety. It is my belief, from fifteen years practicing medicine and a decade working in Vermont, that optometric surgical privileges will lead immediately to three dangerous and costly problems. First, inappropriate surgery due to mistaken diagnosis. Second, poor surgical technique that will have no therapeutic benefit. Third, surgical complications that will aggravate illness rather than treat it.

I ask you to consider the final test: When you have glaucoma, when your own child needs eye surgery, when your elderly parent is losing vision from glaucoma—in these most personal examples, where do you seek treatment? From the well-intentioned person who studied a classroom course and watched videos? Or from a person with nearly a decade of training and a tested foundation in the diagnosis and surgical treatment of disease?

I urge you to reject this proposal and thereby maintain the high standards of medical care and caution in the state of Vermont. Thank you for your time and careful consideration. I'm happy to take questions.