Testimony to Senate Committee on Government Operations
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To the chair and committee members, thank you for allowing our testimony this afternoon. I am Dr. Amy Gregory, president of the Vermont Ophthalmological Society. I am a comprehensive ophthalmologist with a solo private practice in Middlebury. I am a cataract surgeon and I perform glaucoma, eyelid, and laser surgeries. I have been in practice for over 20 years, 11 years here in Vermont and prior to that, 10 years in the state of Oklahoma.

As ophthalmologists, we are here to ensure the continuation of high patient safety standards for tertiary and surgical eye care in this state. This is not by any means a "turf battle". They are knowledgeable and educated professionals providing essential services in primary eye care. The issue under discussion here, however, is not primary eye care. It is surgical eye care which is currently provided, and should continue to be provided, by ophthalmologists: physicians with extensive surgical training. The fund of knowledge, educational background, and clinical training between optometrists and ophthalmologists is markedly different.

Today, we bring the same concerns presented just last year to the House Committee on Government Operations when Vermont optometrists first sought expanded scope of practice to include surgery. Last year's House Bill 104 included language for dramatic optometric scope expansion and prompted the extremely thorough and data-driven OPR study conducted over this past year. The OPR study addressed many of the arguments brought forth by optometrists seeking surgical authority including access to care. The study definitively concluded that there were no access issues for the eye surgeries in discussion. There are no pent-up demands or months-long waiting lists for lasers and eyelid surgeries. Appropriately trained ophthalmologists are readily available throughout the state to provide for the surgical eye care needs of Vermonters. The OPR study results showed this. Please reference the access binder tab showing that 96% of respondents to a VOS survey can accommodate referrals for a laser procedure or lid lesion treatment within one week if requested by a referring provider.

In Vermont and the vast majority of US states, eye surgery is restricted to ophthalmologists; medical doctors with a 4 year postgraduate degree who go on to complete an additional 4 years of nationally accredited medical and surgical residency training.

In medical school, students learn about the entire human body. Most medical students complete 2 years of basic science coursework followed by 2 years of clinical rotations in various areas of medicine. Medical school trains students to draw blood, place intravenous lines, safely handle hypodermic needles, scalpels, and sutures. Students are trained in universal precaution procedures to prevent the unwanted transmission of infectious diseases. They also learn sterile techniques necessary for preventing surgical infections.

A medical school graduate has direct experience managing patients in all aspects of medicine and this is important because patients with eye disease often have medical disease. The eye is

not an isolated structure existing in space like a plastic model. It is an extension of the brain, a window into the cardiovascular system, a precious sensory organ within a living human body. I use the knowledge I gained in medical school every day in my ophthalmology practice including internal medicine, cardiology, neurology, dermatology, even psychiatry. Having an appropriate fund of medical knowledge is particularly imperative in making decisions about and performing eye surgery.

After completing medical school, ophthalmologists complete a full year of medical or surgical internship prior to starting residency.

During residency, there is one-on-one mentored, progressive, surgical training with experienced faculty surgeons over 3 years. Surgical competency is continuously assessed, monitored, and overseen by attending physicians. Residents have minimum requirements for outpatient visits, laser surgeries, and incisional surgeries. Not only are there minimum requirements, there are requirements for showing **competence** and **proficiency** in performing these surgeries. We spend countless hours in lectures, labs, clinics, hospital emergency rooms, and operating rooms such that by the time we complete residency, we have between 17 and 22 thousand hours of clinical experience. There is enormous oversight during this entire process.

Ophthalmology residents don't just learn the mechanical skills of surgery, they learn pre-surgical judgment, when a procedure should be appropriately performed and when it should not. They learn the nuances of performing laser and eyelid surgeries in patients with complex medical conditions and how to handle sight-threatening surgical complications. They learn how to handle anxious, jumpy, flinching patients who can't keep their eye still. Ophthalmologists are also trained in obtaining appropriate informed surgical consent and assessing patient competency for medical decision making.

The surgical authority optometrists are requesting in this language could allow hundreds of unlisted eye surgeries, but let's look specifically at glaucoma lasers. There is an unfortunate tendency for optometrists, and probably the general public, to minimize the risks and potential complications of surgery performed with lasers. Lasers are powerful technology that can blind an eye. Executing laser eye surgery is not a simple process although it may look quite straightforward, even easy, when performed by experienced surgeons. As one who routinely performs such surgeries, I can assure you there is nothing simple or easy about them. Many cases can be particularly difficult and challenging. Unexpected eye motion or delivering laser energy even a few thousandths of a millimeter off of the intended target can permanently damage critical internal parts of the eye.

There are only 2 states, Oklahoma and Kentucky, where optometry school graduates have any actual training using lasers on human beings as these are the only two states with optometry schools and optometric laser authority. No northeastern states allow optometrists to perform eye surgery. If, in the vast majority of optometry schools, including those nearby in Massachusetts, NY state, and Pennsylvania, students cannot perform these procedures on patients, how are graduates of these schools truly being "trained" in eye surgery? Surgery

cannot be learned by observation. Model eyes are not substitutes for human eyes. Cadavers are not substitutes for living tissue. How do you learn to control bleeding without blood?

The 32 hour post-graduate optometric education courses that purport to cover injections, eyelid lesion removal, chalazion treatment, suturing, and 3 different types of lasers in a long weekend are wholly inadequate for surgical training and again, involve no hands-on clinical experience with live patients. The optometric board certifications for lasers and procedures that have been mentioned by state optometric leadership are written tests and skill exams performed on models. Such certifications cannot be equated with a license to perform eye surgery and in no way approach the education and extensive training possessed by a Board Certified Ophthalmologist.

Before concluding, I'd like to touch on the topic of costs. In our current fee-for service system, fees are fixed. Optometrists and private practice ophthalmologists are reimbursed equally for the services they provide. Costs for surgical procedures do not go down because more providers are doing them. Some studies show they may actually go up, resulting in an increased financial burden to our health care system. More MRI machines usually means more MRIs done, not cheaper MRIs. Ophthalmic lasers are significant investments in the tens of thousands of dollars and the numbers of laser procedures currently performed in Vermont fall woefully short of warranting additional "supply".

Patients who need eye surgery deserve the best-trained doctors. The state of Vermont should not lower the bar by reducing standards for eye surgery and putting our citizens' eyes at increased risk for harm.