Senate Government Operations
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Dr. Jessica McNally, MD testimony

Good afternoon. My name is Jessie McNally, and I am the current President of the Vermont Ophthalmological Society. I appreciate having the opportunity to come and talk to the Committee. I know that you have heard hours of testimony on this issue, and I have watched and reviewed it along with you. There has been a lot of information that has come out, and I think that it's worth going through a few things to have a better understanding of the surgeries that are being requested now that we have a list.

Back in 2019, I became involved with the initial bill when it was presented to the House Committee on Government Operations. I had the opportunity to sit down with OPR and spend a lot of time going through the questions that were being asked at the time. There's been a lot of documentation and testimony brought to the Committee this year which has been overwhelming for me and I'm guessing for you as well. I was initially hoping that this bill would go to one of the health care committees, so I'm glad to hear that it will be reviewed there. This is a complex issue, at least in regard to hearing testimony. I think the hard thing for the Committee is that, in the end, you are being asked to decide who is competent to do eye surgery in Vermont, and that is a big responsibility.

I would like to initially touch on the education issue, which has been a sticking point throughout this testimony. We've had a lot of national optometric figures come in front of the Committee and attest to the sufficiency of the training that's provided for surgery in current optometry education. We've had some very detailed testimony about different lectures that are part of optometric education, and there are curricula and information that was given to OPR after their report which may delineate some of this. However, for myself, I haven't heard in testimony or seen in any documentation evidence that there is any kind of standardization of surgical training within optometric education. I understand the testimony that has been given about rotations where optometry students from one program may rotate through another program in another state for a certain length of time. It is true that certain states allow these surgeries to be done on live human beings, and I would be interested in knowing where students may be rotating and for how long (a few weeks, a few months?), what kind of observation they are getting. I continue to be surprised and confused that, after the years that some of this scope expansion has been present in certain states, there is still no documentation that gives us any kind of idea of the hands-on on live patient requirements in order to graduate from optometric school. What I am understanding, based on the testimony of the optometrists, is that everyone who currently graduates from an optometry training program has received enough surgical education that they would be allowed the endorsement. The word competency can be used in different ways, and we may want to talk about what a competency assessment in surgical training means for an ophthalmologist vs. an optometrist.

Madame Chair, you have expressed your concern over the years when you hear about one group of people trying to keep another group of people from training or from practicing to their full scope. I

understand that these are controversial issues. I think it's worth going through some photographs so that you have a better idea of what these surgeries entail. The photos are not gratuitous, and I won't be showing photos that demonstrate complications. The optometrists have already testified that they feel they are prepared to handle untoward events when they do procedures.

- I'd like to first review an item that is not on the list of requested procedures. It is on page 8 of the bill as introduced. It refers to an anterior chamber paracentesis. An anterior chamber paracentesis is when we put a needle or a small scalpel into the eye where the white part meets the colored part. This is mentioned as an emergency treatment to reduce pressure in the eye. This intervention would typically be utilized in the immediate postoperative period, for example by a Retina surgeon after a retina injection or a Glaucoma surgeon. I have never needed to do this procedure for this reason and cannot think of a scenario when I, as a comprehensive ophthalmologist, would need to do it.

- The next item I'd like to address is the use of a laser to create a capsulorhexis prior to cataract surgery. The anterior capsulorhexis is the most important part of cataract surgery. It involves making an opening in the shell that surrounds the cataract so that we can gain access to it for removal. If it isn't done perfectly correctly there can be devastating consequences during the cataract surgery. This is not something that is done right now in VT. There are no ambulatory surgery centers doing this in VT. In addition, this is not anything I was trained to do because it is not part of standard ophthalmological training. Therefore, I cannot see how it can be considered part of the current scope of optometric graduates because it is not part of my scope.

- The next photo is an injection of fluorescein dye. This requires that an IV be placed in the arm. An orange-yellow colored dye is injected through the IV and circulates throughout the bloodstream then into the eye where photos can be taken. This is typically done by a Retina doctor or a Neuro-ophthalmologist to determine diagnosis and treatment of different retinal or optic nerve diseases.

- The next photo is of an injection into the subconjunctival space. I believe, Madame Chair, that Dr. Kim has sent you this photo and perhaps the entire Committee. There is a needle that has to go under the very thin membrane that covers the white part of the eye. This is called the conjunctiva. (I think most of us have heard the word conjunctivitis/pink eye before). Different medications can be injected such as anesthetics if a concerning conjunctival lesion is to be removed. Steroids can also be given with this type of injection.

- The next photo is of a chalazion excision. This is what most people would call a "stye". To treat this, we must give an injection of anesthetic into the eyelid. This is not a superficial injection.

This an injection into the deep tissues of the eyelid. The eyelid is then turned upside down and a sharp blade is used to cut into the inside of the eyelid to release the materials inside.

I think that when we talk about excising lesions of the "eye" and the "adnexa" and the "eyelids", we need to be very clear on what we're saying. A skin tag is not the same thing as every other type of lesion. There are innumerable lesions that can be seen on the eyelids which can range from cysts to different types of bumps. One of the things that I have learned in my years as a surgeon is that eyelid lesions can be unpredictable. I will bring someone to my surgery room, numb up their eyelid, and remove the eyelid lesion and the skin around the area will open up. The skin separates after the lesion is removed, and all of the sudden you have an opening or a hole in the eyelid that you did not expect. Then I have to ask my technician to grab the sutures to suture something that I hadn't expected would need suturing. People's definitions of skin tags will vary from one person to the other. Personally, everything that I take off, I think of as an eyelid lesion. I do not differentiate between a skin tag and anything else that I am taking off. I think it is a grave mischaracterization, and I will quote from previous testimony that was given to the Committee, to describe any kind of surgery as "straightforward, relatively painless, and typically lasting one to five minutes". That is simply not the case. No surgery is straightforward, and any surgeon will tell you that. It is not straightforward for the surgeon, and it is not straightforward for the patient. Every single time a patient comes into my office, and I sit them down in the exam chair and explain to them the procedure that we're going to do, I tell them that there is a chance of vision loss or loss of the eye. And they look at me and they're usually stunned, and some of them will leave because I've told them the truth and that scares them. These are not straightforward surgeries no matter what kind of surgery you are talking about. These are not simple. All surgery is complex. And as a surgeon I think about all the different kind of things that could happen as I'm doing the surgery, in the middle of the surgery, and prior to the surgery.

I'd like to clarify a couple of things. There are 2 things on the list that has been presented to the Committee that are not in the scope of standard ophthalmological surgical training. I was not trained on these, for example.

- The first one is the laser capsulorhexis that I mentioned earlier where a laser is used to create the opening to gain access to the cataract during cataract surgery. This is something that requires training beyond standard ophthalmological surgical training.

- The other item is the corneal cross-linking. This is a surgery that requires fellowship training, typically a Cornea fellowship. This is not training received in a standard ophthalmology residency program. An ophthalmologist has to do their standard years in surgery training and then do further training before they can be approved to do corneal cross-linking. Since this is not standard in ophthalmology training, I cannot imagine how it could possibly be part of optometry training and thus be in their scope.

I would also like to address some of the testimony about the VA. There have been some very specific questions involving laser privileges and recent policy changes. Senator Clarkson, you had a question during the last testimony to clarify if optometrists are doing these types of procedures of increased scope throughout the country. You were given the answer “yes”. The correct answer is “no”. The VA system does not allow optometrists to perform surgeries or lasers. There has been a recent directive change in the VA, but it is still clear in the language that ophthalmologists are the ones who are approved to perform lasers within the VA system. This is certainly not happening in White River Junction. I would pose to the Committee that if there are optometrists out there performing surgeries within the VA system, and the Vermont Optometric Association has knowledge of this, they are obligated to bring those names and information forward to the Board so that it can be reviewed because this is against VA policy. If the Committee feels that optometric surgical education is complete because optometrists are required to go through VA rotations where they will become experienced in doing these procedures on live patients, then you are being misled.

It is extremely concerning to me that this list has been presented to OPR, presumably in good faith, with items on it which are not part of standard ophthalmological training and therefore cannot possibly be part of optometric training. It is extremely worrisome to me that there has been testimony about VA rulings and policies and that that testimony has not been completely straightforward or transparent.

I believe that the Committee should take into consideration carefully, before they pass this through, the fact that there is no documentation that has been received that provides evidence of standardized training for surgery in optometric education. I implore you all to think very carefully about the role that you have in this decision. My patients do not know the difference between an optometrist and an ophthalmologist. Many of the questions that I’ve heard from the Committee during these testimonies have made it clear that a lot of people, including yourselves, may not have known what the differences are between optometry and ophthalmology.

You are the safety net for the people of VT. I cannot expect my patients to know the difference between my training and the optometrist who I may work with. But I hope that after listening to all this testimony you have a better understanding of what the difference is and that you will consider very carefully the responsibility that you have to the people of Vermont and to their health and welfare and safety. And that when they do opt to have surgery and when the decision is made that an eye surgery is appropriate, that is done by someone who is indeed well trained to do it.