Delaney Curran, MD

Testimony in Opposition - S.64

An act relating to amendments to the scope of practice of optometrist

May 6, 2026

Thank you all for having me here to speak today. I'm Delaney Curran. I am the chief resident at the University of Massachusetts in Worcester in the ophthalmology department. I have a 4-year Bachelor's Degree in Biology and a 4-year Medical Degree from the University of Vermont. And after my 4-year residency in ophthalmology is completed, I will be returning to Vermont in September, where I have been hired as a comprehensive ophthalmologist at the University of Vermont. It is a privilege to be able to return to the state of Vermont with the skills to help this community, after all this place has done for me in the past.

I felt compelled to testify today in opposition to act S.64 as written, out of my desire to advocate for the patients of Vermont. I have worked with several skilled and talented optometrists during my training at the University of Massachusetts and am fully aware of how excellent optometrists are at providing quality eye care to patients. However, I have been very freshly exposed to the steep learning curve for the surgeries that are being proposed as additions to the optometrists' scope. I'd like to share with you my experiences with what is involved in both learning the technical skills and also some of the softer less clearly defined skills required to do these types of surgery safely and effectively for our patients.

The first and probably most obvious requirement to be a surgeon is to be technically capable of performing the steps of the surgical procedure start to finish. For ophthalmologists, there is a national council called the Accreditation Council for Graduate Medical Education (aka the ACGME) who holds all residency programs and residents accountable for meeting certain standards prior to graduating residents to operate independently. There is a list of surgeries that we are required to meet "minimum case numbers" on as primary surgeons under the supervision of a board-certified attending ophthalmologist. I will mention that the minimum numbers required of us are more rigorous than those required of the optometrists in this proposed act. Additionally, these

minimum numbers do not tell the whole story of the extent of our supervision and training. Often prior to being allowed to even attempt to do a surgery as "primary surgeon" there are months in which the supervising physician will only let you as the resident practice a couple of the steps, slowly adding more of the steps each time as you grow proficient with the step previously, until you finally are able to do even the most complex parts of the case. Because of this, it can take many repetitions with many different patients before you can even begin to "count" the cases towards your minimum requirements. For example, as a resident, I have done 18 YAG lasers as the "primary surgeon" (the minimum is 5), but I have done some of the steps of nearly 40 YAG lasers in order to gain the proper proficiency before I started being able to do full cases start to finish. This is all for patient safety, with the attending always present to step in if there is difficulty or a complication, able to give you as the learner tips as to how to do things better, and ensure you don't accidentally acquire bad habits. The reason for the steep learning curve is that the eye is very small and filled with important and fragile structures, such that being even a fraction of a millimeter in the wrong space can have serious long-term consequences for the patients. And even after mastering the "standard procedure," throughout my 3 years of ophthalmology residency I also experienced the more challenging variations, unexpected bleeding, uncooperative patients, really dense scar tissue, etc. In those moments, even if you as a resident have technically met your minimum numbers are still required to have an attending supervisor present, and I am grateful for this. The true test of competence comes at this point, from having been taught how to adjust the standard to adapt to the trickiest of patient scenarios. What is worrisome is that the current act is proposing that optometrists only need to practice the surgical procedure on 2 patients before being signed off as independent. I do not know of a single ophthalmology resident who would have felt comfortable operating independently with 2 repetitions of any of the surgeries being proposed in this act.

An additional layer to this is that the ACGME gave these "minimum numbers" recommendations with the assumption that every ophthalmology resident has a certain amount of fundamental knowledge about the basic principles of surgery already. As a medical student, we are all required to do about 2 years of lectures with rigorous exams, followed by 2 years of clinical hands-on rotations, many of which are 60-80 hour weeks. Every medical doctor is required to do "core rotations" which means we all have done surgery, internal medicine, family medicine, neurology, OBGYN, pediatrics, psychiatry, and emergency medicine. After that, medical students often choose electives that cater to their interests (more surgery if they like surgery, more pediatrics if they like pediatrics, etc) This is followed up by an intern year, which is your first year as an MD or DO and often for ophthalmologists requires rotating through all sorts of specialties acting as the "first call

provider." I will speak for myself when I say that I rotated through neurology, ICU, emergency medicine, plastic surgery, general surgery, trauma surgery, anesthesia, among others. This means that before becoming an ophthalmology resident, we have already had 3 years of hands-on experience clinically that are essential to being a good surgeon.

The first time that I did an eyelid laceration repair was as a first-year ophthalmology resident. Eyelid lacerations are often more difficult to repair than lacerations elsewhere on the body due to the small size, location to delicate structures, and importance of the eyelid continuing to function to protect the eyeball. However, going into my first eyelid laceration repair, I had already performed dozens of laceration repairs on other parts of the body. Considerations such as how to prevent infection and clean the wound, how to anesthetize the area with lidocaine, how to pull the skin together to prevent scars, how to maintain proper tension, and how to select the right type and size of suture are all learned with repetition over 3 years in the emergency room, family medicine, surgery and OB/Gyn rotations. When it was finally time to suture an eyelid laceration for the first time, I still had a lot to learn about the specifics related to the eyelid anatomy, but the rest of the skills were already engrained, routine, and straightforward. This is true of all the surgeries in question in this act, there is a foundation to them that was learned by me in medical school and intern-year that made the ophthalmology-specifics much easier to absorb and learn.

The requirement in this act for optometrists to obtain some of these important fundamentals is a 32 hour course, plus 8 hours of hands-on time with 2 repetitions of each surgery. If I had been set free independently at this stage of my learning curve (which is the equivalent to 3 or 4 days as an ophthalmology resident by hours), I would have not been ready to practice safely. For me, I required many more repetitions with supervision to become proficient with these skills, even with a strong fundamental background that medical school provides.

I'm now going to pivot and discuss some of the "softer skills" of surgical training which are much more difficult to measure but may be even more important than being able to do the steps of the surgery.

First, evaluating a patient before surgery and deciding whether to do surgery (or not) is nuanced and is one of the last things I learned to do independently in my residency.

Concepts such as: should or could we stop their blood thinner medications? Can they lay flat for the surgical procedure without experiencing respiratory distress? Is their diabetes well-controlled enough for them to heal appropriately? Is that stye actually skin cancer? Is that eyelid laceration suspicious for involving the tear drainage system requiring a completely different method to close? Is the vision actually going to improve with a YAG laser or was there a complication of their cataract surgery that needs to be addressed first with a second surgery? These are all incredibly important things to consider before signing people up for surgery. Many of these things are taught in medical school and intern-year before ophthalmology residency starts, and then many of these other things are taught during the 3 years of ophthalmology residency where every day we are exposed to these conversations and decision-making opportunities with our patients, with the guidance of our mentors.

Additionally, a good and safe surgeon is trained in how to manage their own complications. This is a skill that is sometimes harder than the actual surgical procedure to be proficient with and takes months or years of managing patients post-operatively. A straightforward example is that sometimes eyelid laceration repairs can become infected after they were sutured. Medical doctors such as ophthalmologists are trained to see the signs of infection everywhere, the feet, the lungs, the bloodstream, the brain, and the eyes. This means our pattern recognition is well-attuned to the early signs of infection and we have experience medically to help us know when the infection is severe, when someone is showing signs of infection in their blood (sepsis), when to send them to the emergency room for labs, cultures, IV antibiotics, what class of antibiotic to prescribe to target the correct bacteria, when to order a CT scan to assess for infection spreading to the brain or orbits. If you do enough surgical procedures, you are going to get complications; infection, bleeding, damage to other structures. Being able to catch these things quickly and act appropriately is what makes you a good surgeon and is something gained with proper experience and supervision over time.

Finally, as a young ophthalmologist, I can tell you that my colleagues in training around me are watching closely to see what you decide before they make their decision about where to set up practice as an ophthalmologist when they finish training. Knowing that a state supports optometrists doing surgery independently after a 40-hour course is unattractive to ophthalmologists, who have spent 12 years in training, 8 of which were specific to medicine, and 3 of which are specific to surgical intervention in the eyes. If the hope is to

increase the community's access to quality eye care with this bill, I caution you that the opposite may actually occur.

I appreciate you all taking the time to hear my testimony today. I hope my message has been made clear, which is that learning any eye surgery is not simple, and there can be dire consequences if done incorrectly. I had years of dedicated hands-on experience from board certified ophthalmologists as well as surgeons and doctors in all other specialties in order to feel comfortable safely performing these surgeries, and I hope any doctor being granted this responsibility and privilege is held to similar standards in the state of Vermont.

Respectfully,

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The University of Massachusetts