Good morning, thank you for having me back on behalf of the Vermont Ophthalmological Society (VOS) and the Vermont Medical Society (VMS). My name is Jessica McNally, MD. I am a comprehensive ophthalmologist at Central Vermont Medical Center, President of the VOS, and a member of the VMS. I am here today to speak in support of Representative Stone's proposed amendment to S.64.

While we have consistently maintained deep concerns about the underlying bill's expansion of optometric scope into surgical domains, we acknowledge that this amendment represents a meaningful and significant effort to incorporate patient safety standards that were absent from earlier versions of S.64. We urge the Committee to adopt this amendment and to examine the remaining concerns we describe below.

The Surgeries at Issue Carry Real Clinical Risk
To evaluate the adequacy of any safety framework for this bill, it is important again to understand what optometrists would be authorized to perform under this amendment.
The surgeries that remain authorized are two categories of in-office surgery: eyelid and adnexa surgeries, and injections. Each carries clinical risk that warrants the oversight structures the amendment puts in place.

- **Eyelid and Adnexa Surgeries**
  The amendment authorizes chalazion excision, excision and biopsy of nonrecurrent lesions of the adnexa, closure of wounds resulting from lesion removal, and repair of eyelid lacerations not larger than 2.5 centimeters and not involving the eyelid margin or lacrimal drainage structures. As described in my previous testimony, these are not minor procedures. The eyelid is a structurally complex, highly vascularized structure only approximately 2 millimeters thick. Surgical complications include bleeding, scarring, infection, and eyeball perforation, which can require further surgery or result in blindness.

  Eyelid lesions cannot truly be identified as benign without pathology, which requires biopsy, tissue transport, and coordination with a pathologist—typically at a hospital. Steroid injections (a therapeutic pharmaceutical agent) into chalazia carry risk of blood vessel occlusion, skin discoloration, and vision loss. Patients can experience vasovagal responses to ocular surgery resulting in loss of consciousness and seizures. It is worth noting that most family physicians, general surgeons, and dermatologists routinely refer eyelid surgeries to ophthalmologists precisely because of the anatomical complexity and the proximity to the eyeball. The ability to manage adverse events is essential for any provider performing these surgeries.

- **Injections**
  The amendment authorizes injections of therapeutic pharmaceutical agents into the eyelid or its adnexa, including into the subconjunctival space, injections to administer local anesthesia, injections to perform fluorescein angiography, and injections of epinephrine for anaphylactic shock. Subconjunctival injections deposit medication using a needle directly against the white wall of the eyeball, called the sclera. Risks include bleeding, infection, misplacement of medication, perforation of the sclera, and sustained elevation of eye pressure and glaucoma if the medication is a steroid.

The clinical complexity described above makes clear why the safety structures introduced by the amendment are not simply procedural; they are clinically essential. We specifically commend the following provisions:

- **Removal of Laser Surgeries from the Authorized Scope**
  A critical safety improvement in the proposed amendment is the removal of all three laser surgeries from the authorized scope of optometric practice. Laser capsulotomy, laser peripheral iridotomy, and laser trabeculoplasty are highly specialized intraocular surgeries that use focused laser energy to target precise structures inside the eye. Surgical risks include retinal detachment, intraocular hemorrhage, intraocular pressure spikes, and permanent visual disturbance or vision loss. The amendment removes all three from the authorized scope by adding them to the prohibited procedures list (§ 1720).

- **Board of Medical Practice Oversight**
  The amendment appropriately places the advanced therapeutic procedures specialty under the jurisdiction of the Board of Medical Practice rather than the Board of Optometry alone. This is not a technical detail. It is one of the bill's most important patient safety protections and deserves particular attention.

  The Vermont Board of Optometry is a five-member board administered through the Secretary of State's Office of Professional Regulation. As of today, one of the two public member seats is vacant, leaving the Board with three optometrists and a single public member. The Board has no physicians on it, no surgeons, and no members with appropriate training or experience in the surgeries this bill would authorize. It lacks dedicated investigative staff, and has no institutional experience evaluating surgical credentialing, reviewing operative outcomes, or adjudicating complaints arising from eyelid surgery or injections. Asking the Board of Optometry to credential and oversee surgical practice would be asking it to regulate a domain entirely outside its expertise and infrastructure.

  The Vermont Board of Medical Practice is a fundamentally different body. It is composed of 17 members: nine licensed physicians, one physician assistant, one podiatrist, and six public members. It is housed within the Department of Health, meets monthly, and is supported by an administrative staff, professional investigators who receive ongoing training in licensing case investigation, and access to legal counsel. It has decades of experience evaluating the competency, credentialing, and conduct of practitioners performing complex medical and surgical procedures. It is, in short, built for exactly this kind of oversight.

When the surgeries at issue include eyelid incisions millimeters from the eyeball and subconjunctival injections that can perforate the eye wall, the regulatory body responsible for credentialing practitioners and investigating adverse events must be able to understand what went wrong and why. The amendment's requirement that the advanced therapeutic procedures specialty be granted and overseen by the Board of Medical Practice, in consultation with the Board of Optometry, reflects a sound and evidence-based allocation of regulatory responsibility.

- **Mandatory Practice Agreement with an Ophthalmologist**
  Section 1724(e) requires a written practice agreement with a licensed ophthalmologist or Vermont-based ophthalmology practice. The agreement must include processes for communication, availability, and joint evaluation, and it must ensure that an ophthalmologist is available for consultation whenever an advanced procedure is being performed or prepared. This is one of the amendment's most clinically important provisions.

  Ophthalmology training equips ophthalmologists not only to perform surgeries, but also to recognize and manage the unexpected. Optometrists, whose doctoral training is focused on primary eye care and does not include a surgical residency, are not trained to the same depth in recognizing or managing these intraoperative and postoperative complications. The difference in patient outcome may depend on whether the treating provider recognizes what they are seeing, knows what to do next, and has a qualified specialist immediately available.

  This is precisely why the collaborative practice agreement is not merely a formality; it is the primary ongoing safety mechanism for patients treated under this expanded scope. When an optometrist encounters something outside their training or experience during a surgery, the agreement ensures that there is a named, accessible ophthalmologist who has already reviewed the practice's protocols, understands the patient population, and can be reached immediately. That relationship—established in advance, documented in writing, and subject to Board review—helps ensure that optometric surgical practice does not become isolated from the physician-level expertise that complications may require.

  The practice agreement also creates accountability beyond individual patient encounters. Section 1724(e) requires processes for joint evaluation of services rendered. In other words, the ophthalmologist is not simply a passive on-call resource, but an active participant in reviewing the quality and appropriateness of the surgeries performed under the specialty. This is the model Vermont already uses in other collaborative practice settings, and it has proven effective at identifying problems early, supporting professional development, and maintaining standards of care over time.

- **Patient Transfer Plan Requirement**
  Section 1724(f) requires a written plan for transferring a patient to a hospital or qualified provider in the event of an adverse event. Complications from eyelid surgery or injections—including ocular hemorrhage and eye wall perforation—may require urgent operating room intervention. A pre-established transfer plan is a basic requirement that any responsible surgical framework should include.

- **Adverse Event Reporting**

Section 1725 establishes a 30-day adverse event reporting requirement to both Boards and a biennial procedure volume report. Systematic reporting is essential for identifying patterns, detecting problems, and supporting evidence-based future oversight of this expanded scope.

- **Strengthened Preceptorship Requirements**
  The amendment significantly increases hands-on training requirements prior to independent practice: minimum supervised clinical hours are raised from eight to 18; required chalazion excisions from two to 12; chalazion intralesional injections from two to 12; and authorized lesion excisions from two to 12. These thresholds are more consistent with the clinical complexity and patient safety stakes of the authorized surgeries.

The safety framework introduced in the amendment is not novel. It mirrors the approach this Legislature has already applied when expanding another non-physician professions into a domain that has traditionally required medical training. Earlier this session, the House passed H.237, which would authorize doctoral-level psychologists to prescribe psychotropic medications. As passed by the full House, that bill included strikingly similar—and in some respects even more robust—structural safeguards: a mandatory practice agreement with a supervising physician psychiatrist, continuing education requirements, two years of training in psychopharmacology, a 14-month clinical rotation, and explicit limits on what could be prescribed.

The parallel is instructive. In both cases, the Legislature confronted the same fundamental question: how do you expand a non-physician profession's scope into clinical territory that carries meaningful patient risk without undermining the safety standards Vermonters expect? The answer the House reached in H.237—additional education, training, collaborative practice agreements, and reporting requirements—is the same approach the amendment before you applies to S.64.

We urge this Committee to recognize that consistency. If the House determined that psychologists prescribing psychotropic medications warranted these safeguards, it follows that optometrists performing eyelid surgeries and injections should at the very least warrant them as well. Adopting this amendment would bring S.64 into alignment with the patient safety framework the Legislature has already endorsed for scope-of-practice expansions this session.

IV. Remaining Concerns

While we support the amendment proposed by Representative Stone as an improvement to S.64, our organizations continue to have concerns about the underlying scope expansion that the Committee should consider:

- Optometrists graduating in 2019 or later are exempt from additional postgraduate coursework on the assumption that their curricula incorporated relevant training. The Committee should verify that current accreditation standards for optometric schools adequately prepare graduates for all the specific surgeries authorized here before relying on this exemption.

- Eyelid lesions require pathology analysis to truly determine whether they are benign or malignant. The amendment authorizes excision and biopsy of nonrecurrent lesions "without characteristics or obvious signs of malignancy," but the Committee should satisfy itself that optometrists are adequately trained to make that threshold determination safely in a non-hospital clinical setting.

- There is a significant mismatch between the surgeries authorized (§ 1703(2)(A)(vi)) and those required to have a preceptorship (§ 1724(c)). The preceptorship mandates demonstrated competency only in chalazion excisions, chalazion intralesional injections, and excisions or drainages of authorized lesions. But the advanced therapeutic procedures specialty would also authorize wound closure following lesion removal, repair of eyelid lacerations up to 2.5 centimeters, corneal crosslinking, subconjunctival injections, injections for fluorescein angiography, and epinephrine injections for anaphylaxis—none of which appear in the preceptorship requirements. The Committee should require that the preceptorship cover the full authorized scope or alternatively limit the authorized scope to what the preceptorship actually trains for.

- The Medicaid parity provision (Section 1901h) should be accompanied by data collection requirements to assess whether access outcomes for underserved populations are genuinely improved.

Vermont patients deserve both access to care and assurance that those providing that care are appropriately trained, credentialed, and accountable. The proposed amendment's removal of laser surgeries from the authorized scope, combined with its practice agreements, Board of Medical Practice oversight, reporting requirements, and strengthened preceptorship standards, moves S.64 meaningfully closer to a framework that takes patient safety seriously. We urge the Committee to adopt this amendment.

We appreciate the Committee's time and the careful work that has gone into improving this legislation. We remain available to answer questions and to continue working toward a final product that prioritizes Vermont patients.

Respectfully,

Jessica McNally, MD
President
Vermont Ophthalmological Society