Good afternoon. My name is Jessica McNally, and I am an ophthalmologist and current president of the Vermont Ophthalmological Society and a member of the Vermont Medical Society.

Chair Birong, thank you for allowing me to testify on behalf of Vermont ophthalmologists to voice our concerns about S.64, a bill that would expand the scope of practice of Vermont optometrists to include eye surgery.

To be clear, the singular goal of Vermont ophthalmologists is to ensure that Vermonters receive safe, high-quality surgical eye care. With that in mind, we have grave concerns about this bill and its implications.

In the close to 20 years I've been in practice, I have seen firsthand the confusion about the difference between an ophthalmologist and an optometrist. Just a few weeks ago I was referred a patient who was diagnosed with a disease that can cause rapid blindness over the course of a day. This patient did not obtain timely and appropriate referral because the PCP (and likely the patient) thought the patient had been seen by an ophthalmologist. The lapse in time between the suspected diagnosis and the appropriate referral may have serious consequences for the patient in the coming years. Two days ago, at a middle school sports event I found myself explaining to another mom that she sees an optometrist and not an ophthalmologist and the difference between the two. In fact, a 2018 survey conducted by the American Medical Association found that over half of respondents either did not know or were not sure if an optometrist was a physician.

All ophthalmologists are physicians and surgeons. Ophthalmologists complete a four-year undergraduate bachelor's degree program after which they complete four years of medical school identical to other physicians and surgeons. After completing medical school, ophthalmologists move on to obtain 4-6 more years of residency and fellowship training. The first year of residency training incorporates in-patient and out-patient care including surgery, internal medicine, emergency medicine, and critical care. Then residents complete three more years of focused training on advanced medical disease and surgery of the eye. The three year ophthalmology residency is standardized in all programs across the country and must meet rigorous, national Accreditation Council for Graduate Medical Education requirements (ACGME).

Many ophthalmology trainees follow up their residencies with another 1-2 year fellowship in a subspecialty such as Cornea, Retina, or Glaucoma, thus giving them more surgical experience and totaling hundreds of cases.

As in all surgical residencies, ophthalmologists are held to the highest standard and do not graduate from their program until they have proven competency, not simply by numbers of surgeries performed or passing board examinations, but by meticulous formal assessments by our mentors. These include elements such as working cohesively with colleagues, professionalism, patient relationships, and surgical skills and progression.

Each member of residency program Clinical Competency Committees must agree that a resident has attained competency before that resident is allowed to graduate.

Optometrists complete a four-year undergraduate bachelor's degree program and then attend a four-year optometric program. They have the option of completing additional training, but this is not required. In the materials provided by Optometry in OPR's second report, examples of such additional training include low vision, contact lenses, and ocular disease. The materials describe education including lectures, videos, and laboratory simulations of surgeries on model eyes and model skin. However, in the numerous curricula supplied, the standardization of this training across Optometric training programs is not clear. What is clear is that in the far majority of optometry schools there is no hands-on surgical training on live human beings. In fact, out of the 25 optometry schools in the Association of Schools and Colleges of Optometry, **only three schools** in three states (Kentucky, Indiana, and Oklahoma) are able to teach all of the surgeries in S.64 on live human beings.

We have observed that the system of licensing optometrists to perform advanced procedures is starting to develop cracks. Recently, it was revealed that Kentucky allowed 21 optometrists to be licensed without passing all of the required exams. A malpractice lawsuit has been filed against one of those optometrists relating to use of a laser. A West Virginia court also recently determined that their Board overstepped its bounds, and they voided a rule that allowed optometrists to perform eyelid surgeries.

The two main arguments that VT optometrists have brought forward since beginning their effort to expand scope involve access and cost. Optometrists in Vermont have repeatedly asserted that by allowing scope expansion, "access" will be improved, but is this access to surgery or access to primary eye care? In Vermont we are extremely fortunate in that we have enough ophthalmologists to provide all medically necessary scalpel and laser surgical care in and around the eye. It has been suggested that the absolute numbers of ophthalmologists in VT does not reflect access because some of us subspecialize and don't perform these surgeries. The fact is that there are only a handful of ophthalmologists (typically Retina specialists) who don't perform any of these surgeries. A July 2023 article published in the Journal of the American Medical Association showed that in Oklahoma, Kentucky, Louisiana, Arkansas, and Missouri, scope expansion to include laser surgeries did not lead to shorter travel time or improved access.

A more recent November 2025 article published in the Journal of the American Medical Association demonstrated that, although there has been a decrease in the number of ophthalmologists, they are practicing in a greater number of locations. The article further determined that, nationwide, driving distances to optometrists and ophthalmologists is similar.

We have approximately 33 practicing ophthalmologists in the state. Not every county has an ophthalmologist. Not every county has a Urologist or a Dermatologist or a

Neurosurgeon either. These are highly specialized physicians and surgeons, and expecting to have a provider with that level of training in all counties is unrealistic. I think we can all agree that we would not be comfortable with Family Practice physicians performing urological surgeries to fill the gaps. This is no different. As we have heard from Optometry numerous times in testimony, they provide primary eye care. Our concern regarding access is that the primary eye care needs of Vermonters are not being met. All diabetics need yearly dilated eye exams. All contact lens wearers need yearly exams. In fact, I recommend that everyone over 50 to get yearly eye exams. It is difficult to understand how expanding the workload of an already busy optometrist to include surgeries could possibly improve access to eye care. Additionally, numerous Vermont optometrists have stopped taking vision insurance, leaving patients to drive distances for routine eye care away from where they live or work already.

Indeed, both the 2020 and 2023 reports from OPR conclude that "OPR is unable to determine whether expanding the optometric scope of practice would improve patient access to care."

I can assure the Committee that if a Vermont patient needs expedited or urgent eye surgery, our optometrists know that they can reach out to us directly. In fact, many of us have each other's personal phone numbers and e-mail addresses.

With regards to cost, many arguments have been put forward by Optometry, insisting that scope expansion will decrease cost. One argument is that the patient could simply be brought to another room on the day of diagnosis and have the scalpel or laser surgery done right then and there. Optometrists argue that this would decrease cost by saving patients a trip to see a surgeon for another evaluation. This argument does not hold water. All ophthalmologists can cite examples of patients who were sent to them for the requested surgeries in S.64 that, after being evaluated, were deemed unnecessary or ill-advised. Other patients opt to not move forward with the surgery once they hear about the potential risks. This in fact decreases cost by avoiding a surgery. Furthermore, it is nearly impossible to perform surgery on the same day of a patient evaluation because of complicated reimbursement issues and obtaining the required prior authorizations.

Optometrists make the argument that increasing scope will make Vermont more attractive to young graduates. There is no evidence that optometrists are flocking to states with increased scope. The laser equipment required to perform the requested laser surgeries can cost anywhere from $40,000-$60,000. The instrumentation for surgeries on and around the eye requires expensive sterilizing equipment. Eyelid lesions that are removed must be analyzed by a hospital pathologist. And, based on OPR's website, VT **is** attracting new optometrists- there have been about 30 new licenses granted since 2021. It is irresponsible to use scope expansion to entice optometrists who we know are not appropriately trained to perform the surgeries in S.64.

Expanding optometric scope of practice to include surgery will not lower costs. The cost for medical services is set by a payment formula created by Medicare, not by traditional supply and demand. Each procedure and service has a code and a set payment. In 1986, federal law established that optometrists would be reimbursed for services by the Centers for Medicare and Medicaid Services (CMS) at the same rate as ophthalmologists. Private insurers use the same set of codes, and their payments are similar to those established by Medicare. Private insurers ALSO reimburse ophthalmologists and optometrists the same amount. The topic of facility fees has come up in the past. These fees are generally applied to hospital-based surgeries and not the office-based surgeries being requested in S.64. Therefore, optometrists performing these surgeries does not save facility fees since there are already none.

The 2023 report from OPR states "OPR is unable to determine whether scope expansion would have an impact on costs".

Optometrists have repeatedly portrayed ophthalmic lasers as "safe" and "easy". The Vermont Ophthalmological Society strenuously rejects this characterization. Ophthalmic lasers, as proposed for use inside the eye, are categorically surgical instruments used for altering tissue. Surgical treatment with ophthalmic lasers is not a primary eyecare service. Furthermore, the existing and future laser eye care needs of Vermonters do not come close to providing the caseload numbers needed for optometrists to maintain competency. I reviewed the laser surgery data from my practice from September – November 2025 and submitted it for review to Senate Health and Welfare. It demonstrates the relatively low numbers of lasers performed compared to the number of referring optometry practices and optometrists.

Optometry scope expansion into the scalpel and injection surgeries listed in S.64 would allow optometrists to remove lesions (what some refer to as "lumps and bumps") on the eyelids and around the eye "without characteristics or obvious signs of malignancy". These surgeries have been described by optometrists as "chairside" procedures. Let me assure you that these surgeries are not "chairside" but are performed under sterile conditions with specialized lighting and equipment. The Oculoplastics specialist at UVM, Dr. Libby Houle, has spoken and written at length about how difficult it is to predict a malignant from a nonmalignant lesion and how that even she, an expert, has been surprised with biopsy results. I experienced this two months ago when I removed an eyelid lesion from a 35 year old woman which was found to be a basal cell carcinoma. A few weeks ago, Dr. Jeff Young had a similar experience of excising a lesion that had "no obvious signs of malignancy", only to be surprised by similar results. We send all specimens to Pathology because of this.

There are technical challenges in removing lesions from the eyelids such as what happens to the skin after the removal; the resulting wound is often much larger than expected once the lesion is cut off. There can be excessive bleeding that can be anxiety provoking for the surgeon and the awake patient. S.64 would allow repair of traumatic eyelid lacerations.

Repair of even superficial eyelid lacerations can be extremely complex and is much more difficult than suturing a surgical incision. Not only that, but S.64 also requires no minimum number of lid laceration repairs to demonstrate competency.

Other proposed surgeries in the bill include corneal crosslinking which is a surgery used to stabilize the surface of the eye (cornea) from certain degenerations. There is only one ophthalmologist in Vermont who is trained to perform this surgery, and that is because he is a fellowship trained Cornea specialist. This surgery is outside the scope of practice of all other VT ophthalmologists, costs thousands of dollars, and is most often performed on a very particular subset of younger patients. S.64 requires no minimum number of corneal crosslinking surgeries to demonstrate competency.

Our Retina surgeons have significant concerns about the inclusion of fluorescein angiography in the bill. This is a dye test to look at structures in the back of the eye. The dye is injected into a vein, often causing nausea and sometimes vomiting and potentially anaphylaxis. Our Retina specialists maintain that the far majority of retina disease can be diagnosed with other equipment that is already widely available and utilized regularly in almost every optometric practice in the state. S.64 requires no minimum number of fluorescein angiograms to demonstrate competency.

Any time a needle or laser is used around, on, or in the eye there is the risk of blindness. We think it is imperative for legislators to understand what these surgeries are in order to make educated decisions about S.64. With that in mind, here is a brief description and photographs of the surgeries:

- Laser trabeculoplasty - a laser surgery that is used to purposely cause damage to the microscopic drainage system of the eye in order to lower the eye pressure
    - Risks include inflammation, elevations in eye pressure after the surgery, swelling of the back of the eye (retina), swelling of the front of the eye (cornea)

- Posterior capsulotomy – a laser surgery used to clear away a film that can develop after cataract surgery on the artificial lens implant. This develops because a few cells from the cataract are always left behind and proliferate over time. The film often does not affect the vision.
    - Risks include inflammation, elevations in eye pressure after the surgery, displacement of the artificial lens, swelling of the retina, retinal tears, retinal detachments, permanent marks on the lens implant “pitting”

- Peripheral iridotomy – a laser that creates a hole in the iris (the colored part of the eye) when the drainage system is in danger of closing- rarely necessary and extremely difficult in an emergency situation
    - Risks include inflammation, elevations in eye pressure after the surgery, bleeding inside the eye, damage to the lens behind the iris

- Chalazion – a lump on the eyelid that consists of a collection of inflammatory cells due to a blocked oil gland
    - Risks of "intralesional injection" of steroid include loss of skin pigmentation, stroke of the optic nerve, perforation of the eyeball and blindness
    - Risks of excision include stroke of the optic nerve (due to anesthetic injection), perforation of the eyeball and blindness

- Excision of lesions of the eyelid and adnexa (structures around the eyeball)
    - Risks include bleeding, infection, perforation of the eyeball, blindness

OPR's most recent report creates a training program for eye surgery, which is labeled a preceptorship. S.64 incorporates some of that model but with even less stringent requirements. With all due respect to OPR and to our Vermont Legislature, we assert that setting appropriate standards for medical and surgical training should only be done by a properly accredited organization. This organization should be comprised of individuals with firsthand knowledge and expertise in eye surgery and developing curricula with proven standardization to ensure competency of surgeons and accountability of the accrediting body. Safe eye surgery for Vermonters can only be provided by physicians who have completed medical school and an ACGME accredited Ophthalmology residency program.

Vermont legislators are not alone in navigating the issue of optometric scope expansion into surgery. Within the last few weeks, the Governor of NH vetoed a bill even less expansive than S.64 and legislation in Maine failed. Understanding eye surgery and the training it entails is extremely difficult.

I will close with where I began, that the singular goal of the Vermont Ophthalmological Society (VOS) is to ensure that Vermonters receive safe, high-quality surgical eye care. As legislators, your ultimate responsibility is to protect the safety and wellbeing of the people of Vermont.

Respectfully submitted,

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