

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 Black, 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 last week I was referred a patient who was diagnosed with one of the most visually threatening diseases we deal with who 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. 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).

The majority of ophthalmology trainees follow up their residency 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 the 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. What we (and what OPR) found is that in optometric programs there are didactics (for example lectures and videos), along with laboratory simulations of surgeries on model eyes and model skin. The standardization of numbers of hours of didactics and numbers of simulations performed is not clear from one optometry program to another. What is clear, and what OPR found, is that in the far majority of optometry schools there is no hands-on surgical training on live human beings. In fact, there are only 2 states out of the 14 with some kind of expanded scope (attached map of states) that have optometry schools that can train their students in all of the S.64 surgeries on live humans. We have been told that optometry programs may be able to rotate their students through these schools, but the amount and type of surgical exposure an optometry student might obtain during such a rotation is unclear.

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. Even optometrists have expressed concern about this lack of responsibility by the Kentucky Board of Optometric Examiners. 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 to these surgeries will be improved. In Vermont we are extremely fortunate in that we have enough ophthalmologists to provide all 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 these surgeries. Furthermore, 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. Furthermore, there are no studies showing that optometrists are flocking to states with increased scope.

We have approximately 33 practicing ophthalmologists in the state. Not every county has an ophthalmologist. Not every county has a Urologist or Dermatologist or 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. Optometrists provide primary medical eye care; they should not perform ophthalmic surgery.

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 all my patients 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. Another major issue we are seeing (and that you may have experienced yourselves) is that numerous Vermont optometrists have stopped taking vision insurance, leaving patients to seek care outside of where they live or work.

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 not to 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.

The laser equipment required to perform the requested laser surgeries can cost anywhere from \$40,000-\$60,000. We relayed to Senate Health and Welfare that we are aware of at least two instances of our patients being told recently by their optometrists that either they had the laser already or that they would be able to perform the laser legally in VT within a

year. This conveys to us that there are some optometrists who assume that this legislation will pass without being fully evaluated by the VT Legislature.

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 an ophthalmologist. Private insurers use the same set of codes and their payments are similar those established by Medicare. Private insurers ALSO reimburse ophthalmologist MDs and optometrists the same amount for medical procedures. 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.

The 2023 report from OPR invalidates Optometry's claims by stating "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 objects to 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 and should be performed by physicians who are hospital residency-trained surgeons. 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. Two weeks ago my partner 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.

Other technical challenges in removing lesions from the eyelids involve what happens to the skin after the removal, for example how the resulting wound is often much larger than

expected once the lesion is cut off. There can be unexpected 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.

Other proposed surgeries in the bill include corneal crosslinking. 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.

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.

OPR's most recent report creates a training program for eye surgery, which is labeled a preceptorship. S.64 incorporates some of that model, 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 two weeks the Governor of NH vetoed a bill even less expansive than S.64 which had been passed by her own party's Legislature. Legislation in Maine failed just this week. Understanding eye surgery and the training it entails is extremely difficult for anyone who does not live in the "world" of eyes.

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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