Chair, Members of the Committee, Thank you for the opportunity to speak with you today. My name is Libby Houle. I am a practicing ophthalmologist here in Vermont. I was born right up the road in Berlin and grew up in Danville. My father practiced general ophthalmology in St Johnsbury for over 40 years. Part of the reason I went to medical school was so that I too could serve the community where I work and live in the way that he did for so many years. Following medical school and residency, I completed a subspecialty fellowship in ophthalmic plastic surgery which gave me additional skills and expertise in medical and surgical treatment of diseases of the eyelids, the orbit/eye socket and the tear drainage system. I then, at long last, returned to Vermont where I have been happily caring for patients and raising my family since 2015.

I am one of 2 oculoplastics specialists in our state. As part of my practice, I commonly remove the "lumps and bumps" referred to in this bill. I always send what I remove to pathology for interpretation, because although I generally have a very good idea about which lumps/lesions are benign and which are malignant or cancerous, I am not always correct in my gross assessment and so I put that ultimately in the hands of the experts in making that determination, the pathologists, because making a mistake about which lesions are benign and which are malignant can have profound implications for patients.

I think that it is also important to note that although these surgeries are called "minor procedures," for the patients on the other end of the scalpel or the laser, these procedures do not feel minor. Patients are often understandably anxious and scared to have an exquisitely sharp instrument millimeters from their eye. Their high level of anxiety is often reflected in their elevated blood pressure which we measure before every procedure to ensure that it is not too high to safely proceed. In my experience, a patient's level of anxiety does not correlate with the level of complexity of a surgery. Shepherding scared and anxious patients safely through these procedures takes skill, calmness, and confidence on the part of the surgeon and the staff. I counsel patients honestly about what to expect from the procedure—the injection of lidocaine into the delicate eyelids to numb them can be quite painful. It is not uncommon for patients to flinch or move during this injection when the needle is one small cough away from penetrating the eye. When a patient flinches or swears or has a full on panic attack, it is essential that I remain calm and relaxed. I can do this because I have had a lot of practice. Throughout my years in training I provided direct patient care and performed a wide variety of supervised surgeries on real patients for up to 80 hours a week under the supervision of skilled and experienced ophthalmologists.

As I am sure you have heard, after medical school, ophthalmologists spend 4 to 6 years in residency and fellowship training, which is hands-on supervised training on real patients. These patients are real people with real disease with whom we build therapeutic relationships, and who place their trust in us as doctors and surgeons in training, under the close supervision of seasoned and experienced supervising surgeons. These supervising ophthalmologists are there not only to ensure our mastery of the technical aspects of surgery, but they are also there to teach us how to think through whether surgery is the right therapeutic option, to ensure we know how to talk to patients about the purpose of the proposed surgery and the associated risks. These

supervising physicians and the patients we care for teach us how to manage complications when they do occur. Learning to do surgery is not just about steady hands and mastering technical nuances and variations, although these are imperative. Learning to be a surgeon is about navigating all these decisions and conversations around the surgery itself. I no longer do many of the surgeries I learned as a resident, because my practice focuses on my surgical subspecialty. But all the patients I cared for and all the surgery I learned during those seemingly endless days and nights as a resident provide the deep and solid surgical foundation I work from every day. A 32 hour classroom course is simply no substitute for thousands of hours in the trenches caring for patients.

Now, I would like to focus on the substance and structure of S.64 as introduced, specifically the training and competency framework it creates for the proposed "advanced therapeutic procedures" specialty. My testimony is really not about professional turf. It is about competency-based training and the implications that has for patient safety which is my primary motivation for testifying here today.

Under S.64, an applicant must complete at least 8 hours of didactic and clinical instruction for each advanced therapeutic procedure and perform a minimum of two supervised cases of each procedure. Only 2 cases.

In most procedural disciplines, whether surgical or medical, competency is not established by exposure to 2 cases. Competency is demonstrated through repetition, graduated responsibility, management of complications, and formal assessment of skill. S.64 does not define how proficiency is evaluated. It does not require objective skill assessments. It does not specify case complexity. It does not require documentation of outcomes.

These are weaknesses of this bill.

This 2 case threshold does not begin to capture the complexity, difficulties encountered or proficiency assessment that are integral to surgical training.

S.64 allows the preceptor to be either an ophthalmologist or an optometrist with "substantially similar scope" for ≥3 years. It also allows an optometrist who gets the specialty by endorsement to serve as a preceptor in Vermont. This means a cohort of optometrists with the newly defined (minimal) specialty could systematically train subsequent cohorts, with no external verification of skill or outcomes.
In contrast, most procedural credentialing systems require preceptors with independent validation of expertise (e.g., board certification, case volume minimums, complication tracking). The bill requires only five additional hours of continuing education every two years to maintain the specialty. It does not require a minimum number of procedures per year to maintain proficiency. It does not require re-evaluation of skills. In a small state with limited case volume, maintenance of competency becomes a central question — and is not addressed.

S.64 includes an adverse event reporting requirement within 30 days. But it does not specify standardized definitions of adverse events, independent review, public transparency, or enforcement mechanisms. Reporting alone is not the same as a safety system. A reporting duty without auditing/verification can result in "no reported complications" narratives. All surgeons who perform surgery unfortunately have complications, so I am highly skeptical of any report or study that claims "no complications." That is simply not possible.

S.64 authorizes procedures that include injections and management of anaphylaxis, but it does not define facility requirements, emergency readiness standards, or transfer protocols.

Finally, performing eye surgery requires providing emergency call coverage for our post operative patients. Failure to provide emergency availability for post operative patients is considered to be patient abandonment. When a patient starts experiencing eye pain at 1am after surgery, they are able to pick up the phone, call or page their surgeon who can address potential post operative emergencies. When you expand procedural authority, you also expand associated risks, complications and responsibility. Infrastructure must expand as well to anticipate and prepare for the increased risks. This is not addressed in this bill.

In summary, when a bill authorizes new invasive procedures, the framework must ensure demonstrable competency, durable skill maintenance, transparent outcome tracking, and emergency preparedness. S.64 lacks all of these.

Again, this testimony is not about professional turf. It is about competency-based training and the implications for patient safety. In my testimony here I do not intend to imply that MD's have some innate or intrinsic ability to perform surgery or that well-trained surgeons are somehow infallible. Neither is true. What we do have are skills and judgment that have been learned and honed over many years of hands-on practical training with graduated responsibility and progressive autonomy based on demonstrated competence. Acquiring these skills takes a lot of practice and a lot of time. It is true that some optometrists, and probably some of you, have the capacity to do these procedures with the proper training. I have a good friend and colleague who initially trained as an optometrist in her native Canada and then decided that she wanted to be an ophthalmologist and surgeon, so she went to medical school and completed residency and fellowship training and is now an accomplished and experienced ophthalmic surgeon. I would gladly send a family member to her if they needed surgery because she has had the training required to make the judgment, perform the surgery and manage any potential complications that ensue. I think that is an appropriate training pathway for someone who wants to perform eye surgery.

This bill contains structural gaps that compromise patient safety, competency verification, and regulatory oversight. And for what reason? Does this bill truly serve the best interest of Vermonters? There has been no demonstrated surgical need beyond what is currently provided by ophthalmologists in our state. The wide gaps in this bill

and lack of adequate standardized training goes to the core of whether Vermonters receive safe, high-quality care.

Those are the concerns before you.

Thank you for your time and consideration.