S.64 testimony

Good morning. I am Jeffery Young a comprehensive ophthalmologist practicing just a few miles from here in Central Vermont for the past 13 yrs. I have been given the opportunity to share some recent and real experiences from around the state that give me pause when considering the wisdom of passing a bill such as S.64 which is before you today. These stories which affected real Vermonters will illustrate the effect that inadequate training and misjudged confidence can have on real patients. I also want to mention that we have received examples from Kentucky and Oklahoma – (which have been submitted) from ophthalmologists that speak to the fact that just because there are no reported "bad outcomes", does not mean that there are not bad outcomes. If a state optometry board says that there has never been a reported "bad outcome" or a single complication, we should all be skeptical. There are either very low numbers being done, or complications are not being recognized, or there is not sufficient follow up to monitor for complications, or if they are seeing complications, they are not being reported properly. I am not here to say that optometrists are worse than or better than ophthalmologists, or to say that they are not concerned with patient safety, but to show that comprehensive surgical training (dealing with simple as well as very complex cases) is necessary to develop proper surgical skill and necessary surgical judgement, and for the highest standard of safety for all Vermonters. Some of the cases are alarming because the optometrist even mentioned to the patient that they would be performing these procedures in a year and the patient could just wait until then, as if the passage of this bill was a foregone conclusion.

Think of these stories as if this was your neighbor, your friend, or even your family member.

First story:

An optometrist, who was a recent graduate from optometry school, referred a patient to an ophthalmologist for evaluation of narrow angles which is a condition that can cause dangerously elevated pressures in the eye and vision loss or blindness. The treatment for narrow angles at risk for angle closure is Laser Peripheral Iridotomy (LPI)- a laser surgery being requested in the bill. Upon examining the patient, the ophthalmologist found that the patient had already had LPIs performed which were clearly visible on the examination. The patient was sent back to their optometrist without having an unnecessary laser surgery. This case is concerning because the optometrist had apparently been trained in these advanced procedures with the modern optometry curriculum and one would assume that this training would allow them to identify whether a procedure had been performed (or whether it was even necessary). As a result, the patient was sent for an evaluation which cost both the patient and the system precious time and money.

Second story:

An optometrist referred a patient to an ophthalmologist specifically for a glaucoma laser procedure. The patient reported that their optometrist described the laser as simple and that optometrists are fully trained to perform this laser, and that it should soon be available in VT without referral to an ophthalmologist.

The laser referral was made by the optometrist's office as a routine (non-urgent) consultation, approximately one month out. The ophthalmologist reviewed the incoming referral within 24 hours of receipt, suspected a more severe condition requiring urgent evaluation, and asked the patient to come in the same day. The evaluation revealed that the patient had been misdiagnosed and was not a candidate for the referred laser. In fact, use of this laser would have worsened the underlying condition and likely would have resulted in permanent vision loss. The proper diagnosis was made, the patient was treated appropriately, and their vision was preserved.

This story is another example of misdiagnosis, inappropriate treatment plan, and delay of care. The request for a non-urgent referral put the patient at risk of vision loss. The laser surgery (one that is requested in the bill) was contraindicated. Had it been performed by the referring optometrist, the patient would have suffered permanent vision loss.

Third story:

An optometrist referred a patient to an ophthalmologist for a YAG capsulotomy (laser requested in the bill). Although the patient did have mild posterior capsular opacification (PCO) behind both of her artificial lenses, she had no visual complaints- no blurred vision with glasses on and no glare. Despite her lack of complaints, she had been referred for the laser surgery. The ophthalmologist felt that proceeding with a YAG capsulotomy in this situation with no medical necessity was contraindicated and did not perform the laser. Furthermore, the ophthalmologist found that the patient's only complaint was about her dry eye which was not being treated adequately and can also cause decreased vision. The ophthalmologist felt that withholding unnecessary surgery and avoiding exposing the patient to undue risk was most appropriate.

This patient was referred for a laser surgery that was not medically necessary. Her main complaints were attributable to dry eyes. Laser surgery would not have been helpful. This case shows that surgical judgement matters, especially knowing when NOT to do a surgery. Proper training, careful listening, and critical judgement are essential in surgical decision-making. The best way to protect patients and control healthcare costs is making sure that only patients who truly need surgery receive it.

Fourth Story:

An ophthalmologist received an urgent referral by an optometrist who had come to the optometrist with eye redness and vision loss. The optometrist noted high eye pressure and believed the patient had narrow angles (a condition I mentioned earlier). The optometrist's diagnosis was angle closure glaucoma with the recommendation to perform a Laser Peripheral Iridotomy (LPI), one of the surgeries being requested in the bill. The ophthalmologist's exam showed that the patient's angles were not narrow but were in fact wide open. The ophthalmologist noted inflammation inside of the eye. The ophthalmologist did not perform the LPI and instead proceeded to investigate the cause of the inflammation (bloodwork and X-Rays). The results revealed that the patient actually had tuberculosis, a rare and serious infectious disease that is life threatening.

In this story the optometrist made an incorrect diagnosis in which performing the laser peripheral iridotomy (a) would not have improved pressure or opened the angle, (b) would have worsened the underlying inflammation since laser surgery always causes some inflammation and c) would have greatly confused the entire situation. What was needed was identification of the eye inflammation and a search for the cause. Which in this case was blood work and chest X-ray, which revealed that the patient had tuberculosis.

What makes this case even more concerning is that the referring optometrist had, that exact same week, published an essay in a prominent Vermont news publication in which they assured lawmakers that optometrists have the proper training and skill to make advanced medical and surgical decisions for care of the eyes. The optometrist's own actions demonstrated that they had significant gaps in expertise that would have harmed the patient and public. In this case, diagnosis of a deadly infectious disease (TB, which must be reported to the State) would have been missed and an unnecessary laser surgery would have been performed on the patient.

I was only allowed a few minutes and have chosen only a few (of many – examples submitted) cases to demonstrate that necessary surgical skill and more importantly proper surgical judgment requires comprehensive training, not cursory courses. It requires graded and guided surgical experience, not just fulfilling a checklist. It requires time, not measured in the 10's of hours but in the hundreds of hours dealing with complexity and complications.