Case examples from Vermont ophthalmologists underscoring differences in education, training, and clinical decision-making between ophthalmologists and optometrists.

Statewide, we have experienced many patient care interactions displaying a lack of knowledge or flawed decision-making by Vermont optometrists. Lawmakers should be very concerned that increasing the scope of practice of optometrists to include surgery will increase risk for patient harm and inappropriate care. We are alarmed about broad reports from different parts of the state where Vermont optometrists are telling their patients they could do surgeries themselves in a year, if they preferred to wait.

Ophthalmologists receive many years of hospital-based medical and surgical training focused specifically on diagnosing and treating serious eye diseases. This training includes managing emergencies, recognizing rare but dangerous conditions, and knowing when NOT to perform surgery. A key part of this training is learning how small symptoms can signal vision-threatening problems.

Optometrists are highly trained in vision care and primary, preventive eye health, but their training typically includes limited exposure to surgical decision-making, medical emergencies, and complex eye disease. Optometrists may rely more on imaging tests/protocols and have few opportunities during training to manage rare or high-risk conditions.

This gap in exposure can lead to:

- Missing early warning signs of serious disease
- Over-reliance on imaging and technology instead of full clinical exams
- Delays in recognizing emergencies
- Referrals that lack clear urgency
- Assuming procedures are “simple” and appropriate when they are not

Our intent in submitting these case stories is to help lawmakers understand our legitimate concerns regarding expanding optometric scope of practice without personal content. None of this is meant to say that optometrists are careless or unconcerned with patient safety. It means their training is different. When those differences are not clearly respected, patients can be harmed. All case stories reference Vermont practitioners and patients.

Story #1:

An optometrist referred a patient to an ophthalmologist with a diagnosis of posterior capsular opacification (PCO), a cloudy film that commonly develops on the back of the artificial lens implant after cataract surgery. PCO can cause decreased vision and/or an increase in glare. It is correctable with a laser surgery called a YAG capsulotomy (one of the surgeries being requested by optometrists).

The patient was diagnosed by an optometrist who said that they had the YAG capsulotomy laser machine in their office and that the optometrist was licensed to perform the laser in another state but not in Vermont. This optometrist then told the patient that they could wait a year and have the laser done in their office. The patient was actively affected and limited by her visual symptoms. Rather than receive an appropriate referral to an ophthalmologist, the patient reported feeling pressured to buy expensive glasses. This patient felt so uncomfortable with the encounter that she sought care with another optometrist who then made the appropriate referral to an ophthalmologist for the YAG capsulotomy laser surgery.

Significance:

This story illustrates how patient care was delayed by not referring the patient to the trained ophthalmologist for the appropriate treatment, thus causing the patient continued and potentially worsening visual acuity affecting their quality of life and functioning. It should raise concerns among lawmakers that optometry practices may be already making business decisions (purchasing laser machines that sell for $50,000) under the assumption that this proposed legislation will pass without moving through the appropriate statutory processes. It suggests that patient care was delayed in favor of future financial gain of the optometrist.

Story #2:

A Vermont ophthalmologist reports seeing many cataract surgery consultations with overlooked severe glaucoma. Ultimately, these patients have cataract surgery for visual rehabilitation (improvement in quality of life and functioning) but have unfortunately suffered irreversible loss of their peripheral vision from glaucoma that was not diagnosed until they were referred to the ophthalmologist for cataract surgery.

The ophthalmologist regularly reviews referral letters from optometrists who document elevated intraocular pressures (a known serious and treatable risk factor for glaucoma) but do not outline a reasonable plan of action for management. There are occasions where the ophthalmologist finds it necessary to call the referring optometrist to confirm that the optometrist has an appropriate plan of action for the patient's elevated eye pressure/glaucoma prior to having surgery.

Significance:

This story illustrates that some patients who are receiving primary eye care by VT optometrists have had undiagnosed severe glaucoma that was not recognized until the ophthalmologist diagnosed it at a routine cataract surgery referral. A lack of diagnosis of such a disease suggests a gap in training or understanding of glaucoma, a treatable but potentially blinding disease. Optometrists already own equipment which can help diagnosis glaucoma and have the statutory authority to treat it with medication/drops. This story should concern lawmakers since one of the surgeries being requested, SLT (Selective Laser Trabeculoplasty), is an intraocular laser surgery used to treat glaucoma. The potential use of SLT by optometrists who have an inadequate understanding of glaucoma is dangerous to Vermont patients.

Story #3:

An optometrist referred a patient to an ophthalmologist for a YAG laser capsulotomy with a diagnosis of posterior capsular opacification (PCO). This patient had known disease of the retina that was, in fact, the underlying cause of their vision loss and not the PCO. The ophthalmologist finds that these patients often are not aware of their other disease process. The ophthalmologist appropriately recommended observation of the PCO and did NOT move forward with YAG capsulotomy.

Significance:

This story demonstrates that patients are being inappropriately referred by optometrists for YAG laser surgery when there are other causes for their vision complaints. This can lead to delay in care by delaying referral to an ophthalmologist trained to manage the true underlying cause of the visual complaints. If Vermont law allowed optometrists to perform laser surgery on this patient, they would likely have undergone an unnecessary surgical procedure.

Story #4:

A Vermont ophthalmologist regularly receives cataract surgery referrals for patients who have easily recognizable and yet undiagnosed diseases of other parts of the eye besides the cataract. Two of these diseases are conditions of the cornea: Fuchs dystrophy and Anterior Basement Membrane Dystrophy. Often, patients are not aware that they have these diseases; their optometrist has either not diagnosed them or has not discussed them with the patient.

Significance:

This story is another example of patients who are referred for cataract surgery when other eye problems may be worsening or causing the vision problems. When optometrists fail to diagnose and discuss these diseases prior to making their referrals, patients may be confused and need additional education at their surgical consultation. Undiagnosed eye conditions can alter cataract surgical planning and may result in delay of treatment. In fact, sometimes other preexisting diseases may lead to a completely different surgery with a different risk/benefit profile than cataract surgery.

Story #5:

An optometrist referred a patient to an ophthalmologist for a chalazion excision. A chalazion is a collection of inflammatory cells within the inner layers of the eyelid due to a blocked oil gland--a stye that does not resolve on its own. Treatment of a persistent chalazion involves injecting an anesthetic medication into the outer and inner parts of the eyelid. The ophthalmologist who saw this patient quickly recognized that this was not a chalazion and performed a biopsy instead, confirming a skin cancer. This necessitated a much more involved surgery requiring excision of the cancer and reconstruction of the eyelid.

Significance:

This story shows how misdiagnosing an eyelid cancer as a chalazion (or other benign eyelid lesions-often minimized as “lumps and bumps” when optometrists speak to lawmakers) can lead to a delay in treatment with very serious consequences. Chalazion excision is one of the requested surgeries in the optometric expansion bill. This story highlights the importance of proper training in recognizing serious eye diseases resulting in dramatically different management and outcome.

Story #6:

An optometrist referred a patient to an ophthalmologist for evaluation of a chronic eye infection. The patient was experiencing progressive visual loss over a period of months. The ophthalmologist diagnosed the patient not with an infection, but with a severe late complication of prior laser vision correction surgery (such as LASIK or PRK). The patient reported being told by their optometrist of good news; the optometrist would be able to repeat the laser vision correction surgery in about a year when the optometrist expected Vermont laws to allow optometrists to perform the surgery. The ophthalmologist made the correct diagnosis, advised the patient their eye condition was not correctable with further laser vision correction, and told them it was critical to never have additional laser vision corrective surgery.

Significance:

This story illustrates the danger in misdiagnosing and mistreating a serious eye condition which resulted in delayed appropriate referral to an ophthalmologist. The optometrist offered the patient a contraindicated laser surgical treatment which would have caused further loss of vision. As mentioned earlier, legislators should be concerned about the apparent assumption by Optometry that proposed legislation will pass without moving through the appropriate statutory processes.

Story #7:

An optometrist referred a patient to an ophthalmologist for a glaucoma laser procedure. The patient reported the optometrist describing the laser as simple, 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/urgent condition, and asked the patient to come in the same day. The urgent 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.

Significance:

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.

Story #8:

An optometrist referred a patient to an ophthalmologist for a YAG laser capsulotomy with a diagnosis of PCO (posterior capsular opacity) causing visual decrease. The ophthalmologist performed a standard dilated eye exam and recognized that the patient did not have a visually significant PCO. Rather, the patient was suffering from wet macular degeneration, a visually threatening retinal disease requiring urgent treatment. After making the correct diagnosis, the patient was referred to an ophthalmologist who appropriately administered treatment (not a YAG laser). The patient's vision was restored.

Significance:

Again, misdiagnosis of eye disease can result in permanent vision loss. If the referring optometrist had performed the unnecessary YAG capsulotomy (a laser requested in the bill), the patient would have been exposed to unnecessary intraocular surgical risks and diagnosis of the true cause for loss of vision would have been delayed.

It is important for lawmakers to understand that years ago a diagnosis of wet macular degeneration (typically seen in older patients) would have meant likely blindness. However, with appropriate and rapid diagnosis, current treatments can successfully maintain a patient's vision and functional independence for the rest of their lives. Correct and timely diagnosis of this condition is absolutely imperative for maintaining vision.

Story #9:

A Vermont ophthalmologist evaluated a patient with flashes and floaters. This patient had been seen one day prior by an optometrist for an exam. The patient was given the option of having a dilated exam with eye drops or having a picture performed without eye drops; this picture was not covered by insurance, and the patient would have to pay out-of-pocket for the test. The patient reported he was told that the picture was just as good as having eye drops, and he opted to pay for the picture. At the end of the visit, the patient reported being told that everything looked good, that floaters are normal, and was advised to keep his regularly scheduled appointment in a number of months.

The patient's family member was concerned and contacted the ophthalmologist. The patient was seen urgently the day the family member called (the day after seeing the optometrist). The patient was diagnosed with a large retinal detachment that would have been obvious with the picture imaging and certainly with a dilated eye exam. The patient was taken to the operating room for emergent repair of his retinal detachment, a condition that can lead to blindness if not diagnosed and treated quickly. The surgery was successful and the patient maintained vision.

Significance:

Symptoms of new floaters can be an indication of a visually threatening retinal tear or retinal detachment. Rather than be provided with the standard of care (a dilated eye exam), the patient was "sold" the picture and was told that it was equivalent, which is not the case. Most importantly, the large retinal detachment was easily visible to the ophthalmologist the following day, suggesting that the optometrist either did not interpret the picture correctly or that the picture did not provide a wide enough view to see the condition which certainly would have been visible had the optometrist performed a dilated exam. We are concerned about a trend of optometrists using cameras/photography (often paid for out of pocket) as a substitute for a dilated eye exam with eye drops, (the standard of care).

Story #10:

A patient complaining of having visual distortion in one eye was followed at sequential visits by their primary eye care optometrist over a period of months. The patient's vision progressively declined until it was worse than legal blindness (ability to see "the big E" on an eye chart). An image of the patient's retina was taken that showed wet macular degeneration. A referral (non-urgent) was sent to the ophthalmologist with a diagnosis of possible dry macular degeneration. By the time the patient was seen by the ophthalmologist the patient had developed scar tissue and the patient remained legally blind in that eye despite treatment.

Significance:

This patient with months-long worsening vision had clear warning signs on imaging tests, was misdiagnosed, and was referred too late. Because of the delay, the patient irreversibly went blind in an eye that almost certainly could have been saved with earlier treatment.

Story #11:

An optometrist explained to their patient the options of having a dilated eye exam using eye drops or having an equivalent picture not requiring eye drops but incurring an out-of-pocket expense. The patient opted for the picture. Using the picture, the optometrist diagnosed an eye cancer and made an urgent referral to the ophthalmologist. The patient was understandably distraught by the diagnosis of cancer. The ophthalmologist performed a standard dilated exam with drops and saw no cancer, reassuring the patient at length. The patient reported experiencing so much anxiety after the optometrist's diagnosis that they had not been sleeping well.

Significance:

This story is important because it illustrates how reliance on eye photos by optometrists rather than full dilated exams can lead to serious errors. In this case, misdiagnosing a nonexistent eye cancer caused severe stress and anxiety in a patient whose eye was completely normal.

Story #12:

An optometrist referred a patient to an ophthalmologist for a YAG capsulotomy (laser requested in the bill). Although the patient did have mild PCO on 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.

Significance:

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. Experience 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.

Story #13:

An optometrist (with a recent degree) referred a patient to an ophthalmologist for evaluation of narrow angles (a narrowing/tightening of the microscopic drainage system inside the eye). The treatment for narrow angles at risk for angle closure (a severe ocular emergency) is Laser Peripheral Iridotomy (LPI)- a laser 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 exam. The patient was sent back to their optometrist without having any unnecessary laser surgery.

Significance:

Optometrists are referring patients for surgeries they do not need and, in this case, already had done. The referral used unnecessary and valuable appointment time, added cost to the health care system, and created undo stress for the patient. It shows how lack of experience can lead to unnecessary referrals. It is additionally concerning that the referring optometrist, recently out of training with current/modern optometric educational curriculum, did not identify the previously performed LPIs.

Story #14:

An optometrist referred a patient for evaluation of a displaced intraocular lens implant (IOL- artificial lens) after cataract surgery many years prior. This is not usually an emergent condition. However, the patient's eye pressure was found to be dangerously elevated and uncontrolled, putting the patient at risk of permanent vision loss. The ophthalmologist felt strongly that the eye pressure was not being adequately managed by the patient's primary eye care optometrists and made a referral to an ophthalmologist specialist. The patient received appropriate care, which in this case was urgent surgery, to lower the eye pressure and preserve the vision.

Significance:

This story demonstrates how crucial proper training is for assessing and prioritizing eye disease. In this case, the patient was referred for a non-emergent displacement of their artificial lens. The visually threatening condition, however, was the uncontrolled eye pressure that was not being appropriately treated and which ended up requiring glaucoma surgery. When serious conditions like high eye pressure are not addressed quickly by the right specialists, patients can suffer preventable harm.

Story #15:

A Vermont ophthalmologist received a referral from a patient's optometrist. A review of the optometrist's notes showed the patient had or was having episodes of vision loss for an unknown reason- the optometrist wondered if it was due to temporary poor oxygenation to the eye or to a displaced artificial lens. The ophthalmologist saw a diagnosis of glaucoma documented, but details weren't clear in the records. The patient was using a glaucoma drop twice a day and, according to the optometrist's note, was to follow up in 6 months. There was no letter of referral accompanying the notes to indicate the exact clinical question that was being asked of the ophthalmologist.

At the exam, the patient's eye pressure was found to be very elevated on the side of concern, and the optic nerve had an appearance concerning for severe glaucoma. The ophthalmologist felt that the eye was experiencing poor oxygenation and that the elevated pressure in the eye was making it worse and that the optic nerve was undergoing continued visually threatening damage despite the current eye drop treatment. The ophthalmologist prescribed an additional eye drop to lower the pressure and referred the patient to an ophthalmologist specialist.

A few weeks later the patient's optometrist, owner of a large optometric practice and one of three optometrists on the Vermont State Board of Optometry, contacted the ophthalmologist and was irate that the ophthalmologist had referred the patient to a specialist and had documented "uncontrolled glaucoma" in the chart. The optometrist felt that the eye pressure was being managed adequately and that the patient just needed counseling on using the drops regularly. The optometrist felt that the ophthalmologist had gone beyond what was asked of them by making the specialist referral.

The ophthalmologist felt there was a complete lack of medical judgement relating to the glaucoma management of this patient by the optometrist. The patient was seen by the appropriate specialist and received appropriate treatment, in this case, glaucoma surgery.

Significance:

Unclear referrals and poor judgment about serious eye disease can put a patient's vision at risk. A patient was sent for an ophthalmology consultation, but it was not clear why, and their medical notes were confusing. The ophthalmologist noted a very high eye pressure and clear signs of damage to the optic nerve, which can lead to permanent vision loss.

The ophthalmologist recognized that the patient's vision problems were likely caused by uncontrolled glaucoma as well as poor blood flow to the eye. Because of this, the patient was referred urgently for surgical glaucoma care. The optometrist did not agree with the plan despite the fact that surgery was indeed necessary to protect the patient's vision. Their angry phone call to the ophthalmologist demonstrates unprofessionalism and lack of judgement which is concerning because they are a member of the VT Board of Optometry. Treating a serious condition like glaucoma as controlled when clear signs show it is not controlled while questioning appropriate referrals for further management is worrisome.

Clear communication, appropriate referrals, and strong medical judgment are critical to preventing avoidable blindness.

Story #16:

A patient was referred to an ophthalmologist with a diagnosis of severe inflammation in the back of the eye and had been started on high dose, high potency anti-inflammatory steroid drops by their referring optometrist. The optometrist's notes indicated that the patient had artificial lens implants that were in place with posterior capsular opacification (PCO) on both lenses to be monitored closely. The eye pressure was elevated at the optometrist's office. The ophthalmologist's exam revealed that the artificial lens was rubbing against the iris and causing blood in the back of the eye, not inflammation. The pressure in the eye was also noted to be elevated by the ophthalmologist. The ophthalmologist saw that this patient had been inappropriately started on a high dose of high potency steroid eye drop, was misdiagnosed with inflammation rather than hemorrhage, and had incorrect information documented in the optometrist's note regarding the presence of a posterior capsular opacity in both eyes (which the patient did not have).

Significance:

Misdiagnosis and the wrong treatment can make a serious eye problem worse. A patient was sent for emergency care with an incorrect diagnosis of severe eye inflammation and was started on a very strong steroid drop. However, when the ophthalmologist examined the patient, the real problem was bleeding inside the eye which is not treated with steroid drops. A known side effect of steroid eye drops is increasing the eye pressure. Use of the steroids could have increased the eye pressure even further and contributed to a higher chance of vision loss. Additionally, there was an incorrect diagnosis of a posterior capsular opacity in both eyes.

Story #17:

A patient was seen by their optometrist for a complaint of flashes and floaters. A photograph was taken. The patient reported being told this was normal aging and not to worry about it. The patient began to lose vision and called their optometrist again. Rather than see the patient emergently that day to evaluate their patient, the optometrist sent the patient to the ophthalmologist where they were diagnosed with a retinal detachment. The ophthalmologist was struck by three things: 1. The optometrist had obviously considered the photograph adequate for evaluating a possible retinal tear or detachment 2. The optometrist did not see their own patient emergently on the day the patient called with

worsening symptoms 3. The ophthalmologist was told that the referral was being made because the optometrist reported they “didn’t have the tools to assess these symptoms”.

Significance:

This patient was reassured there were no problems after only having eye photos taken (rather than the standard of care dilated eye exam). The necessary tools and standard of care for evaluation of flashes and floaters are a dilated exam with eye drops, easily available to all optometrists. A reliance on photos instead of a full eye exam can be unsafe; in this case, missing a retinal detachment.

Story #18:

An optometrist referred a patient for YAG laser capsulotomy. The consulting ophthalmologist did not feel that the amount of PCO adequately explained the patient’s decreased vision and noticed other abnormalities on the eye exam. Imaging testing was done, and wet macular degeneration was diagnosed. An urgent referral to a specialist was made to initiate treatment for the vision threatening macular degeneration. The ophthalmologist then received an irate phone call from the patient’s optometrist, who owns multiple optometry practices, demanding to know why the ophthalmologist hadn’t simply gone ahead and performed the laser surgery the day the patient was in the office. The ophthalmologist explained that they felt it was most important to take care of the time sensitive visually threatening disease process and address the much less concerning PCO later. In order to satisfy the optometrist and with considerable effort, the ophthalmologist coordinated a visit with one specialist for the macular degeneration on the one eye along with a visit with a different specialist for the laser surgery on the opposite eye, all on the same day.

Significance:

This story underscores how essential it is to accurately diagnose the true cause of vision loss. This patient had a delay in treatment because the underlying visually threatening disease (wet macular degeneration) was not diagnosed. Instead, the patient was sent for a routine laser surgical evaluation (YAG capsulotomy). It also illustrates that appropriate training and experience are required when making decisions about eye surgery. In this case, the optometrist was angry that the laser was not performed even though the patient had a separate visually threatening disease process going on which needed to be addressed immediately. The ophthalmologist demonstrated good medical judgement in proceeding with the safest option for the patient despite the fact that the optometrist was angry about the decision. Again, it is concerning that an experienced optometrist misdiagnosed a well known eye disease and then demonstrated unprofessionalism in their interaction with the ophthalmologist, especially since the optometrist is a member of the Board of Optometry.

Story #19:

An optometrist sent a referral to an ophthalmologist for a patient with a diagnosis of glaucoma. The referral process seemed inadequate in the opinion of the optometrist. The optometrist reached out to the practice manager to explain why they thought the patient needed to be seen. The ophthalmologist reviewed the notes, agreed with the referral, and the patient was scheduled. An addended note later became available to the ophthalmologist which stated the optometrist's plan to contact the practice manager to discuss the referral, and if the patient was not seen the optometrist would contact the Medical Director and WCAX to discuss why optometric scope expansion should happen in the state. Upon reading the addended note, the practice manager contacted the referring optometrist to discuss that this addendum was inappropriate documentation in the patient's medical record. The addendum was ultimately removed from the patient's record.

Significance:

An optometrist's threat to involve media as leverage for specialty consultation is unprofessional at best. Documentation in the patient's medical record was completely inappropriate. This kind of threat does not focus on what is best for the patient and undermines trust in an already unsteady healthcare system. Medical referrals should be based on patient need and clinical judgment, not leverage, coercion, or financial incentives. Mutual respect is essential to safe and effective healthcare.

Story #20:

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 narrowing/tightening of the microscopic drainage system inside the eye). 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.

Significance:

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 (the laser surgery always causes some inflammation), and c) would have greatly confused the entire situation. What was needed was a search for the cause of the eye inflammation. In this case, blood work and chest X-ray 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 VT Digger 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, crucial 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.