Oklahoma Academy of Ophthalmology
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May 2, 2025

The Honorable Donna Bailey and Kristi Mathieson
Chairs, Committee on Health Coverage, Insurance and Financial Services
Maine Legislature
Maine State House
2 State House Station
Augusta, ME 04333

Dear Chairs Bailey and Mathieson and Members of the Committee:

We are urging Maine's lawmakers not to enact legislation that was unfortunately adopted in our state of Oklahoma. Specifically, we are writing to ask that you oppose LD 1803, which would allow optometrists—who are not medical doctors or trained surgeons—to perform eye and eyelid surgery on the citizens of Maine.

As the leading organization representing Oklahoma's ophthalmologists—medical doctors specifically trained in eye surgery and comprehensive medical eye care—we have all too often heard those in the optometry profession claim to lawmakers in other states that there have been "great experiences and no complications" with regards to surgery being performed by optometrists in our state and that there have been "no complaints" made to the state's board of optometry. To hear these assertions is alarming to us, as many of our members have had to treat far too many complications or mistreated patients by optometrists attempting to perform some of the same surgeries (which often turned out to be the incorrect treatment for the patient's conditions) authorized in LD 1803.

We would like to share just a handful of professional observations and concerns based on a few sample patients, which demonstrate that a mere weekend worth of "additional training" (32 hours)—which is all that would be required for optometrists to perform the surgeries outlined in LD 1803—is grossly inadequate as a pathway to become properly trained to perform eye surgery. Allowing optometrists to perform surgical procedures in Oklahoma has ***not*** increased access and has indeed caused patient confusion and complications. The patient summaries below are various examples:

- **Patient #1:** A patient who—after months of evaluation for a painful red eye by not one, but TWO different optometrists—was (finally) sent to the emergency room for pain relief. The medical doctor on staff at the emergency room (not the optometrists) diagnosed chronic angle closure glaucoma and referred the patient to an ophthalmologist. A peripheral iridotomy (which optometrists would be authorized to perform in LD 1803) would have been an appropriate early treatment, but due to delay in diagnosis and scar formation from lack of a proper diagnosis the patient required a much more invasive

glaucoma filtering surgery. The two optometrists that repeatedly saw the patient (and failed to properly diagnose or refer to an ophthalmologist) were "laser certified" by the Oklahoma Board of Examiners in Optometry (the same certification requirements that Montana optometrists would need to meet in LD 1803). The patient filed a lawsuit against the optometrists, but died shortly thereafter. While the cause of death was not necessarily due to his ocular issues, it technically ended any litigation against the optometrists.

- **Patient #2:** This patient was a woman with symptoms of visual distortion in one eye. Her optometrist performed a laser iridotomy (which would be authorized for optometrists to perform under Maine's LD 1803). In this surgery, a laser is used to burn a small opening in the iris so that fluid can flow through the hole and move forward, thereby deepening the front chamber of the eye. The objective of performing this procedure is to decrease the pressure in the eye if the drainage system angle is narrow or blocked. In this example, the optometrist performed this surgery in both eyes of the patient. The patient continued to experience visual distortion and sought a second opinion from an ophthalmologist.

    - Records from the optometrist were obtained and reviewed. There was no documentation of history or examination findings to warrant the laser surgeries. There was however, documentation that insurance would pay for the laser surgeries. Only after visiting an ophthalmologist, was the patient that properly diagnosed the cause of her symptoms of distorted vision—a wrinkle in the retina**. The patient did not need the laser surgeries that the optometrist performed, and the insurance company paid for unneeded an unnecessary surgery.** Net result - patient risk without any chance of benefit, and increased health care costs, not to mention failing to diagnose and treat the patient's actual problem. **Exactly the opposite of the goal of medical care which is patient benefit and the lowest risk with reasonable cost.**

- **Patient #3:** Another patient presented emergently to the hospital after an optometrist attempted to perform a laser iridotomy and encountered hemorrhaging at the surgical site. The optometrist could not proceed with the surgery and left the laser opening incomplete. The optometrist then moved to the second eye and tried to perform a laser iridotomy and once again encountered hemorrhaging and could not complete the procedure. The bleeding in both eyes resulted in very elevated eye pressures, which then became an emergency. An ophthalmologist, a medical doctor and surgeon, came to the aid of the patient, addressing the complication.

    - There is no doubt that performing these procedures requires the proper level of medical education, clinical surgical experience and the judgment that comes with years of medical and surgical training to learn not to put patients' vision at risk. A significant part of an ophthalmologist's training consists of performing complete surgical cases on live patients under the direct supervision of an attending surgeon over a period of three years. This cannot be obtained in the optometry school 32-hour training course.

    - Even with ophthalmology's medical and surgical residency training that is established and proven to be necessary to perform eye surgery proficiently and

safely, complications may still occur. If one decreases the education and experience legally required to perform these procedures, there is no doubt there will be *increased* complications. In the case of Patient #2, he realized that he had to go to another doctor who could take care of his problem and he went to the hospital. It later was identified that the patient was on anticoagulants. The patient said he had told the optometrist about his anti-coagulant use, but the optometrist said it would not be a problem. However, to anyone properly trained, it ***should not*** have been surprising for the patient to hemorrhage. The patient was hospitalized and managed by ophthalmologists at the hospital. **Ultimately it was determined that the patient did not even need the laser treatment that the optometrist performed.** From the weekend laser course (which is all the "additional training" required for optometrists in Oklahoma to legally perform the procedure, as it would be in Maine), **the optometrist clearly did not understand if the laser treatment was needed and did not recognize the significant risks for this patient.** The patient suffered damage to both eyes and there were high additional costs that were entirely unnecessary. Poor quality of patient care with increased costs is not what patients in Oklahoma or Maine deserve.

- **Patient #4**: A patient was supposed to receive a YAG capsulotomy (which would be authorized in LD 1803) from an optometrist. However, the optometrist could not adequately visualize the posterior capsule with the slit lamp (a microscope with a bright light used during an eye exam to provide a closer look at the different structures at the front of the eye and inside the eye.) Therefore, a special lens was utilized for improved visualization of and laser administration to the posterior capsule (a thin membrane that forms a physical barrier between the anterior and posterior segments of the eye). **Unfortunately for the patient, the optometrist selected the wrong lens, so the laser was focused on the retina instead of the posterior capsule. A focused YAG laser treatment was administered by the optometrist to the macula (in the back of the eye) resulting in immediate damage with resultant scarring of the retina and permanent blindness in that eye.**

- **Patient # 5:** A patient diagnosed with acute angle closure by an optometrist was referred to an ophthalmologist for laser iridotomy (a surgery authorized in LD 1803), **but only because the optometrist did not have access to a laser at that time.** However, when the patient was examined by the ophthalmologist, the patient did NOT have acute angle closure, but rather had neovascular glaucoma. Not only was a laser iridotomy NOT the correct procedure to perform on this patient, but it would have been extremely harmful if one had been done in the setting of neovascularization of the iris which would have resulted in hemorrhaging in the eye, and worsening of the eye pressure with NO alleviation of the underlying disorder. The patient's condition would have been made worse if this optometrist's diagnosis and treatment plan were followed. If skilled slit lamp exam was utilized instead (which should have been done with this patient, but was not), this would have been diagnosed properly in the first place.

The fact is complications and mistakes indeed happen during some laser eye surgeries. To claim zero complications amongst optometrists or any practicing health practitioner should raise significant questions on: data collection methodology, the practitioners' ability to recognize an adverse event, the practitioners' ability to perform the necessary patient follow up to check for

adverse events after surgery, or simply refusal to self-report any complications. Any of which on their own or in combination should raise tremendous concern about professional standards and capabilities.

The five aforementioned patient cases are just the tip of the iceberg. **The truth is that Oklahoma's Board of Examiners in Optometry <u>does NOT</u> collect data on surgery outcomes, and as such, Oklahoma optometrists have no reason to self-report complications and adverse outcomes from their surgeries.**

Our member-ophthalmologists in Oklahoma have also had certain situations where patients came in and said that while getting new glasses, the optometrist saw a "minor lump or bump" on the eyelid and told them they needed to have it removed. The optometrists wanted to surgically excise the eyelid lesion. Fortunately, the patients did not consent to this. What turned out to be a "minor lump or bump" turned out to be small cysts that did not need to be surgically removed.

The five patient cases highlighted above demonstrate the significant negative impact on the safety and quality of care—*with increased costs*—when a state legislature enacts a bill that decreases the educational and clinical training standards to perform eye surgery.

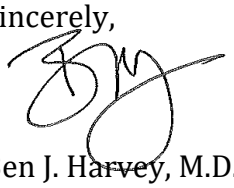
As a professor of ophthalmology who teaches residents to perform surgery, it is an extended process over the course of three years (but only after they complete medical school) to educate future ophthalmologists on:

- How to medically diagnose;
- How to know what the management should be *if* surgical intervention is even the appropriate option;
- Which procedure is the best treatment for that patient's specific conditions;
- Recognize potential risks of the procedure, and;
- How to immediately handle any surgical complications that arise during or after the procedure.

None of this experience can be gained in optometry school or in any 32-hour weekend course.

In Oklahoma, scope of practice expansion for optometry to include surgery has *not* resulted in increased access, but it has *increased patient risk with higher cost of care* due to lowering of the educational and training standards. For the sake of maintaining patient safety and the quality of surgical eye care, while controlling costs, I urge you and your colleagues to protect the citizens of Maine by rejecting LD 1803.

Sincerely,



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