# Kentucky Academy of Eye Physicians and Surgeons

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May 1, 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 understand that your committee is considering LD 1803 in the Maine Legislature. We are writing to inform you about a similar bill that was regretfully enacted in our state in 2011, which was misleadingly titled *Access to Quality Eye Care* (Kentucky Senate Bill 110). Similar to Maine's LD 1803, the bill in Kentucky allowed optometrists—who are not medical doctors or trained surgeons—to perform a wide range of surgery on and around the eyes using lasers and scalpels. Since its enactment, the law has in no measurable way expanded access to quality eye care as it was sold to our lawmakers at the time.

You may be hearing from proponents of LD 1803 who claim there have been "no complaints" or "no adverse outcomes" from optometrists performing the surgeries authorized as part their scope of practice expansion in some other states. Unfortunately, for a number of patients across the Commonwealth of Kentucky, those claims are simply not true. The following cases are just the tip of the iceberg after consulting with only a few ophthalmologists, and many more exist:

- Eastern KY: While performing a needle injection of anesthesia into an eyelid, a Kentucky optometrist and "teacher of optometry surgery" accidentally went through the eyelid and directly into the eye. This is a grave complication, yielding endophthalmitis (blinding eye infection) a retinal detachment, or toxic issue from the drug in the needle.
- Central KY: In an adult patient who had pediatric cataract surgery and was stable for decades, an optometrist lasered the vital capsule that was separating the two chambers of the eye, causing a severe glaucoma with eye pressures three times what is normal, resulting in permanent harm to the optic nerve. Fixing this tragedy took two operations by ophthalmologists (medical doctors and trained eye surgeons).
- Eastern KY: While attempting to perform a YAG capsule surgery, another "teacher of optometric surgery" subjected a patient to a multi-hour procedure. This procedure takes a seasoned ophthalmologist about 5 minutes. These struggles yield multiple laser injuries to the lens of the eye and corneal abrasions.
- Eastern KY: While attempting to remove a "benign" eyelid lesion, a "professor of optometry surgery" used another provider's loupe magnifiers and proceeded to use the dull edge of a #11 scalpel.
- Central KY: A patient who saw an optometrist for a peripheral iridotomy on one eye was subjected to having the procedure done multiple times, over multiple visits. For her second eye, the patient begged the practice to have an ophthalmologist perform the surgery so it would be performed correctly the first time.
- Central KY: An optometrist performed a laser peripheral iridotomy (PI) on a patient with neovascular glaucoma, when laser PI isn't indicated at all! This delayed a patient's care causing further glaucoma damage.

These surgical complications are in addition to numerous misdiagnoses, inappropriate therapy and overlooked problems by Kentucky Optometrists that many of our members have personally treated. There are multiple cases of missed corneal infections, inappropriately treated corneal ulcers, and missed glaucoma that were never reported because there is no medical board oversight or supervision of optometrists in Kentucky, and optometrists here are not required to report adverse outcomes or complications to their licensing board. The absence of a malpractice lawsuit or a recorded complaint filed with the board of optometry does not equate to the absence of harm to the patient.

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As was the case in Kentucky, you are also probably hearing that LD 1803 will expand "rural access" for patients requiring surgical eye care. While there was already sufficient coverage of ophthalmologists statewide prior to the bill introduction in Kentucky, its enactment over a decade ago has not expanded rural access to these procedures in any statistically significant manner. After a thorough analysis of Medicare claims data, peer-reviewed research has shown that despite expansion of laser privileges to Kentucky optometrists, ophthalmologists continue (as they had prior to 2011) to serve an overwhelmingly higher percentage of the population for these procedures. This conclusion comes as no surprise considering there are only about 33 optometrists statewide performing these procedures, and most of them are in our populous urban cities like Louisville and Lexington.

You may also be told by supporters of LD 1803 that malpractice insurance premiums have remained flat for optometry since being allowed to perform surgery. This is in no way indicative of whether these procedures are safe for them to perform. The stability of optometric malpractice rates is proportional in nature. The majority of optometrists in the United States do not perform laser and incisional surgery. A statistically miniscule number of individuals performing these procedures on and around the eye will yield a very small number of opportunities for malpractice as compared to the rest of the entire profession. Therefore, this will have a minimal impact on insurance rates—for now. This does not mean that the procedures are safe for optometrists to perform, but rather there are statistically so few of them doing these procedures which in turn, does not expand access to any significant degree. Allowing providers with substandard training to perform surgery on and around the eye is not in any way an increase in "access" to safe quality surgical eye care for rural America.

There is nothing "simple" or "minor" about eye surgery and that is why an ophthalmology resident-in-training spends three years diagnosing, treating, and operating on live patients with real conditions under direct one-on-one supervision of an attending ophthalmologist after completing medical school. Regardless of what proponents of LD 1803 may imply, there are frequent complications when it comes to surgery, and it takes the proper level of medical education and training to immediately handle those complications as they arise.

For example, a critical rescue procedure for managing an eyelid bleeding complication simply cannot be experienced in an optometry school, especially given that 22 out of the 25 U.S. schools of optometry are located in states where optometrists are legally prohibited from performing incisional surgery with a scalpel. Furthermore, 23 of the 25 schools are in states where optometrists are prohibited from performing laser surgery. This translates to 95% of optometry students attending schools where optometrists are prohibited from performing laser surgery on live patients. One cannot possibly learn how to become an eye surgeon and manage surgical complications with such an inadequate training curriculum. That's why medical school, internship, and surgical residency exist and are vitally important components of surgical eye care.

In the interests of patient safety, we do not want to see the state of Maine make the same mistakes as the Commonwealth of Kentucky—mistakes which have led to increased costs for patients, threats to their vision, and no meaningful increase in "rural access" to surgical eye care. We ask that you give our comments full consideration, and that you vote "no" on LD 1803.

Sincerely,

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