Goldthwait Vision Care
"You'll See the Difference"

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Thank you Senator Bailey, Representative Mathieson, and committee members for allowing me to testify in favor of Bill 1803. My name is Phil Goldthwait, and I have been practicing optometry for 37 years. As the owner of a private practice in Bangor, I serve patients from all over Maine especially in the underserved Downeast region of Maine.

I am here to emphasize the critical need for Doctors of Optometry to perform essential in-office ocular procedures such as YAG capsulotomy, selective laser trabeculoplasty (SLT), peripheral iridotomy (PI), and chalazion removal.

While opponents of LD 1803 may argue that there is little need for these procedures as they encounter them less frequently than high-volume interventions like catarract surgery or intravitreal injections, such comparisons overlook the clinical necessity and accessibility issues tied to these services. Utilization reports consistently show that thousands of patients undergo these procedures each year and those numbers represent real people whose quality of life and vision depend on timely intervention. For example, in the United States a YAG capsulotomy is the 3rd most commonly billed procedure for eye care and is the 69th most commonly performed procedure for all medical specialties (ie oncology, dermatology, cardiology, etc)[1]. For these to be such commonly billed procedures indicates the volume and need for our ever-aging patient population to have better access to these procedures.

A YAG capsulotomy, for instance is not optional; it is often the only way to restore functional vision in patients who have developed clouding of the membrane behind their implant after cataract surgery – a condition that affects up to 50% of patients at some point postoperatively.[2] Likewise, SLT and PI are front-line therapies for open angle glaucoma and angle-closure disease, conditions that can lead to irreversible vision loss if not managed proactively.[3] Stye removals alleviate pain, infection risk, and significant cosmetic concerns that impact patients' daily lives.

When these non-surgical procedures are needed, they are needed urgently and appropriately. Restricting access based on volume statistics disregards the practical realities of rural care, patient mobility, and subspecialty access.

The ability of trained providers to offer these services where patients live and in optometry offices, not just in ophthalmology practices, is what ensures equitable, timely, and cost-effective care. There is ample utilization and need. I urge you to consider not just the numbers, but the patients behind them.

Thank you,
Dr Goldthwait

Resources:

1) Corcoran, S.L. (2016, February). Coding & reimbursement. *Ophthalmology Management.*
2) Schaumberg DA, Dana MR, Christen WG, et al. A systematic overview of the incidence of posterior capsule opacification. 1998. In: Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews [Internet]. York (UK): Centre for Reviews and Dissemination (UK); 1995.
3) Dewundara, S. (2020, March). SLT earns a place as first-line therapy. *Ophthalmology Management,* 24(3), 16-18.