

**STATE OF VERMONT
BOARD OF MEDICAL PRACTICE**

In re:	)	MPC 15-0203	MPC 110-0803
	)	MPC 208-1003	MPC 163-0803
David S. Chase,	)	MPC 148-0803	MPC 126-0803
	)	MPC 106-0803	MPC 209-1003
Respondent.	)	MPC 140-0803	MPC 89-0703
	)	MPC 122-0803	MPC 90-0703
	)		MPC 87-0703

MOTION TO ALLOW DEFENSE WITNESSES

I. Introduction.

The Board should allow Dr. Chase to present the expert testimony of Dr. David Evans and Dr. Arthur Ginsburg, as well as the fact testimony of 12 of Dr. Chase's former patients. Prior to the merits hearing, the Board ruled that these witnesses should be excluded because their testimony would be irrelevant or cumulative. Since then, however, the State has chosen to present evidence that has rendered these witnesses not only relevant, but crucial to Dr. Chase's defense.

Because the State chose during its case-in-chief to attack Dr. Chase's use of CST and BAT testing, the testimony of Drs. Evans and Ginsburg, both of whom are experts on the use of CST and BAT testing in the clinical setting, is now central to Dr. Chase's defense. And because the State has argued that Dr. Chase's informed consent presentation to surgical patients was designed to coerce them into surgery, it has made relevant the testimony of other former patients of Dr. Chase, who will testify that the very same presentation provided them with valuable information regarding their surgery decision, and was therefore not inherently coercive.

It would unfairly and unconstitutionally compromise Dr. Chase's defense if he is precluded from presenting this testimony. The additional witnesses will consume no more than

two additional hearing days. Nonetheless, their testimony will guarantee that the Board's verdict is properly founded upon all of the available, relevant, and non-cumulative evidence. For all of these reasons, Dr. Chase should be allowed to present the testimony of his patient and expert witnesses, including Drs. Evans and Ginsburg.

II. Discussion.

During its case-in-chief, the State chose to present evidence calling into question the propriety of Dr. Chase's use of CST and BAT in cataract diagnosis and treatment. It also introduced testimony that Dr. Chase's decisions to offer cataract surgery to patients with early cataracts, good Snellen scores, but significant contrast sensitivity and glare deficits were improper. Through this evidence, the State has directly challenged the validity, accuracy, and importance of CST and BAT and has denigrated Dr. Chase's particular use of CST and BAT as improper. As such, it has made relevant Dr. Chase's expert testimony regarding the validity of contrast sensitivity testing in general and his own testing methods in particular.

In addition, the State has presented evidence that Dr. Chase's standard cataract informed consent presentation, in which he spoke of second opinions and his credentials as a cataract surgeon, was designed to discourage second opinions and coerce his patients into cataract surgery that they did not really need. By choosing to present this evidence, the State has made relevant the testimony of other patients who received the same presentation, but who found it to be informative and educational. Those witnesses will demonstrate that Dr. Chase's presentation contained nothing that was inherently misleading or coercive, as the State claims.

Finally, both the expert and patient witnesses will confirm that Dr. Chase's CST and BAT procedures accurately reflected and measured his patients' real-life visual deficits, often better than the Snellen scores relied upon by the State's experts. This evidence further rebuts the State's claims that Dr. Chase's surgery recommendations were improper.

A. The Standard For Cataract Surgery Emphasizes Patient Choice And The More Comprehensive Nature of CST.

The State has stipulated that the American Academy of Ophthalmology's Preferred Practice Pattern ("AAO PPP") contains the standards governing cataract diagnosis and treatment. The AAO PPP states that cataract surgery is appropriate when the patient's "visual function no longer meets the patient's needs and . . . cataract surgery offers a reasonably likelihood of improvement." *American Academy of Ophthalmology, Preferred Practice Pattern, Cataract in the Adult Eye*, at 15 (2001).

All of the State's own physician witnesses also agree, and the AAO PPP makes clear, that high-contrast Snellen acuity testing does not identify many of the functional visual disabilities caused by cataracts. According to the PPP, glare testing provides important additional information regarding patients' functional disability from cataract:

Cataracts may cause severe visual disability in brightly lit situations such as ambient daylight or from oncoming auto headlights at night. Visual acuity in some patients with cataracts is normal or near normal when tested in a dark examination room, but when these patients are retested using a source of glare, visual acuity (or contrast sensitivity) drops precipitously.

Id. at 14.

Most of those same physicians agree that contrast sensitivity testing is a more comprehensive way to detect loss of functional vision due to cataract, as confirmed by the PPP:

Contrast sensitivity testing measures the eye's ability to detect subtle variations in shading by using figures that vary in contrast, luminance, and spatial frequency. ***It is a more comprehensive measure of visual function than visual acuity, which determines perception of high-contrast letters and numbers [by use of Snellen testing].***

Id. (emphasis added). The State's doctors have all admitted that patients with decreased contrast sensitivity are more likely to have difficulty seeing in low light conditions, such as driving at

night and reading in dim light. The PPP confirms that cataract patients with contrast sensitivity deficits are, in fact, much more likely to be involved in automobile accidents. *Id.* at 10.

Finally, the State has stipulated into evidence a recent peer reviewed article published in the AAO's premier professional journal, entitled "Lens Opacities Associated With Performance-Based and Self-Assessed Visual Functions." *See* Respondent's Hearing Ex. 819. The main conclusion of that article, and the comprehensive study that it summarizes, is that "lens opacities even in relatively early stages are accompanied by diminished visual function." *Id.* at 1262. Among the visual deficits caused by early cataracts is a significant loss in contrast sensitivity, which is in turn associated with real-life vision problems. *Id.* Although it has known of this study since the outset of the hearing, the State has chosen not to ask its expert witnesses to review it or testify regarding it. As a result, its conclusions have gone unchallenged.

B. The State Admits That Nearly All Of The Complaining Patients Have Early Cataracts And Low Contrast Sensitivity Scores.

According to the State's own physician witnesses, all but one of the 11 complaining patients had early or moderate cataracts.¹ The State does not challenge the fact that all of the 11 complaining patients demonstrated contrast sensitivity and glare deficits when they were examined by Dr. Chase. Indeed, none of the 11 patients achieved normal CST with BAT scores

¹ The State contends that one patient, Helena Nordstrom, had no cataracts. Ms. Nordstrom has refused to be examined by Dr. Chase's experts. However, her medical records, both from Dr. Chase and the State's expert Dr. Morhun, strongly support Dr. Chase's diagnosis. Although Ms. Nordstrom's glasses prescription did not change between the time she saw Dr. Chase and Dr. Morhun, her vision improved dramatically, both according to her own description and the tests both doctors performed. Because that improvement cannot be attributed to any glasses change (because there was none), it must be attributed to some other ocular change. It is Dr. Chase's contention that, if she really had no cataracts when examined by Dr. Morhun, Ms. Nordstrom most likely suffered from transient metabolic changes in her lenses that are visually and functionally indistinguishable from typical cataracts. This contention is supported by Dr. Chase's contemporaneous medical records, which document his concern that Ms. Nordstrom had blood sugar problems. Dr. Morhun has provided no other credible explanation for her vision change. If Ms. Nordstrom had undergone the blood test ordered by Dr. Chase, the identity and cause of those metabolic cataracts would have been revealed. However, Ms. Nordstrom chose not to follow Dr. Chase's medical advice, did not inform Dr. Morhun of the changes in her vision or Dr. Chase's diagnosis, and instead filed a complaint against Dr. Chase, touching off the summary suspension proceeding and all subsequent patient complaints.

on the dates that Dr. Chase proposed cataract surgery, even though many had achieved normal scores on prior visits before their cataracts had formed or advanced.

C. The State Has Attacked The Utility And Validity Of Dr. Chase's CST And BAT Testing.

None of the State's second-opinion doctors performed CST on the 11 complaining patients. Only three of the 11 patients received glare testing, even though nearly all of them indicated that they were experiencing some form of glare. Instead, the State's physicians relied primarily on Snellen testing to gauge the visual significance of the patients' cataracts and the severity of their visual complaints. Because most of the patients achieved good Snellen scores, the State's physician witnesses found that their symptoms were not significant and surgery was not appropriate. Although the AAO PPP indicates that contrast sensitivity is actually a "more comprehensive measure of visual function" than Snellen visual acuity, the State's doctors all ignored or discounted the results of Dr. Chase's CST and BAT in evaluating the visual significance of those same cataracts and visual complaints.

In asking the Board to credit the opinions of its own physician witnesses over those of Dr. Chase (who performed both CST and BAT on each of the 11 patients), the State is implicitly but directly challenging the validity, accuracy, and usefulness of Dr. Chase's contrast sensitivity and glare testing in the diagnosis and treatment of visually significant cataracts. In effect, the State is asking this Board to rule that Dr. Chase was wrong to rely on his CST and BAT in assigning significance to the cataracts he observed in his patients' eyes and the visual complaints they made.

Indeed, it is difficult to understand how the State could hope to prove its central allegations against Dr. Chase without challenging Dr. Chase's reliance on CST and BAT. According to the State's own witnesses, none of the 11 patients had ocular problems other than

early cataracts and refractive error. It is undisputed that Dr. Chase's office always performed CST and BAT utilizing the patients' best corrected visual acuity, thereby eliminating the effect of uncorrected refractive error. It is also undisputed that those patients nonetheless demonstrated significant contrast sensitivity deficits when compared with age-adjusted norms. Thus, if Dr. Chase's CST and BAT accurately identifies significant visual deficits, Dr. Chase was correct in concluding that the patients' cataracts were visually significant, their complaints were significant, and that surgery was appropriate if the patients desired it. Challenging the validity of Dr. Chase's CST and BAT testing is therefore a sine qua non of the State's claim that Dr. Chase recommended and performed unnecessary cataract surgery---the primary allegation in this case.

The State has also introduced direct physician testimony that CST lacks standardization, does not provide significant information, and is therefore unhelpful as a diagnostic tool. Dr. James Watson testified that contrast sensitivity testing did not yield additional valuable diagnostic information beyond that provided by patient interviews. Dr. Irwin testified that CST was of limited utility in diagnosing visually significant cataracts because, although he had never performed or studied CST, he believed that it lacked standardization. Dr. Morhun echoed these concerns, even though he has adopted CST in his own practice since this case began.

Finally, the State has argued, through questions to its witnesses and the testimony it has elicited, that Dr. Chase's particular method of testing contrast sensitivity---using the sine wave test in conjunction with the BAT on its highest setting---overstated his patients' true functional visual disability. For each patient, Dr. Chase testified that he relied on the results of his CST and BAT to help him assess and confirm the severity and source of his patients' self-reported symptoms. To a one, the State's second opinion doctors felt that the patients' self-reported symptoms were not sufficiently bad to justify cataract surgery, thereby calling into question whether Dr. Chase's CST and BAT methods did, in fact, accurately test his patients' true

functional vision. If, as the Respondent claims, Dr. Chase's particular contrast sensitivity and glare testing methods accurately reflected the extent of his patients' real-life visual complaints (rather than overstating them), the State's allegations of unnecessary cataract surgery lose nearly all of their force.

D. Dr. Ginsburg And Dr. Evans Will Directly Rebut The State's Claims And Bolster Dr. Chase's Defense.

In response to the State's evidence, Dr. Chase seeks to introduce the testimony of Dr. Arthur Ginsburg and Dr. David Evans, both of whom are world-renowned experts regarding contrast sensitivity and glare testing.

1. Dr. Ginsburg Is Uniquely Qualified To Testify Regarding A Study That He Personally Performed Demonstrating The Validity Of Dr. Chase's Specific Testing Procedures.

Dr. Ginsburg is a vision scientist. He has a Ph.D. in biophysics from the University of Cambridge, England, an M.S. in bioengineering from the Air Force Institute of Technology, and a B.S. in systems engineering from Widener College. Dr. Ginsburg is the founder and president of the Visual Forensics Corporation. He has devoted most of his career to the research and development of advanced functional vision testing methods and products. In his work as a vision scientist, Dr. Ginsburg routinely tests subjects and develops clinical test equipment and protocols for ophthalmic clinical studies using contrast sensitivity, glare and night driving simulation. Dr. Ginsburg has invented and patented contrast sensitivity and glare test systems and visual analysis software. He is a member of the FDA subcommittee on vision standards, including contrast sensitivity and glare testing.

Because he helped draft the FDA guidelines endorsing Dr. Chase's method of contrast sensitivity and glare testing, Dr. Ginsburg will directly counter the State's evidence that CST is not sufficiently standardized to be useful to clinicians. Dr. Ginsburg also performed an

experiment specifically designed to determine whether Dr. Chase's particular CST and BAT methods overstated his patients' real-life visual deficits, as the State claims. That experiment revealed that Dr. Chase's CST and BAT methods accurately identified visual deficits that are functionally significant according to the FDA's own criterion. Indeed, Dr. Ginsburg concluded that the CST thresholds that Dr. Chase utilized in his practice, and during his examination of each of the 11 complaining patients, were "conservative and highly justified." (Arthur P. Ginsburg, "Analysis of Contrast Sensitivity And Glare Criterion Used By Dr. Chase For Cataract Surgery," at p. 16, (copy attached hereto as Ex. A).) The results of this experiment directly refute the State's own claims regarding Dr. Chase's testing methods.

The State was provided with a copy of Dr. Ginsburg's study more than two years ago. It deposed Dr. Ginsburg at length regarding the study. The State raised no objection to Dr. Ginsburg testifying at the originally scheduled merits hearing in September 2004. It was only after Dr. Ginsburg testified during Dr. Chase's federal trial, and after Dr. Chase was acquitted based in part on Dr. Ginsburg's testimony, that the State suddenly concluded that his testimony should be excluded from this Board proceeding as "irrelevant." The timing of the State's efforts to exclude his testimony speaks loudly of its real motivations.

The Board rejected the State's argument that Dr. Ginsburg's testimony is irrelevant, but nonetheless excluded it as unduly "cumulative." As set forth above, Dr. Ginsburg is uniquely qualified to testify regarding the specific study he personally performed in conjunction with this very case. That study will address the State's argument that Dr. Chase's CST and BAT methods did not accurately detect, and in fact overstated, his patients' real-life visual deficits. There is no other witness who can testify regarding that important study, and the State has not argued to the contrary. As a result, Dr. Ginsburg's anticipated testimony is both highly relevant and non-cumulative.

2. Dr. Evans Is Uniquely Qualified To Testify To The Proper Performance And Interpretation Of The VectorVision CST.

Dr. Evans has a Ph.D. in ocular physiology from Indiana University and a B.S. in human factors engineering from the United States Air Force Academy. The focus of his training was evaluating the relationship between visual function and ocular physiology. After graduating from the Air Force Academy, Dr. Evans joined the Air Force Medical Research Laboratory Aviation Vision Lab, where he concentrated on quantifying and predicting the quality of vision and its relationship to real-world performance. Along with Dr. Ginsburg, Dr. Evans has demonstrated through peer reviewed studies that contrast sensitivity is a much better measure of many visual functions than is Snellen testing. Although the State refuses to acknowledge it, this proposition is now well accepted within the ophthalmic community. Drs. Evans and Ginsburg have also demonstrated, through peer reviewed studies and publications, that contrast sensitivity loss correlates better with many real life visual deficits than does Snellen visual acuity. Working closely with medical doctors, Dr. Evans has demonstrated the usefulness of CST in detecting and verifying contrast sensitivity loss due to cataracts. Like Dr. Ginsburg, he is a member of the FDA subcommittee on vision standards, including contrast sensitivity and glare testing.

Since 1984, Dr. Evans has played a major role in the commercial development of contrast sensitivity and glare testing products. In 1987, he founded VectorVision, where he developed and patented the first self-calibrating vision testing product. Dr. Evans is currently the President of VectorVision Inc., which sells the particular CST device used by Dr. Chase to evaluate all 11 patients named in the Superceding Specification. Dr. Evans developed the age-adjusted norms printed on the CST recording slips that Dr. Chase used to assess the visual significance of the cataracts of each of the 11 complaining patients.

As the developer and producer of the VectorVision CST used by Dr. Chase, Dr. Evans is uniquely qualified to testify that, contrary to the Government's arguments, Dr. Chase's use of the device was proper and consistent with the manufacturer's intended purpose and use. He is also uniquely qualified to interpret the results of the contrast sensitivity testing Dr. Chase performed on the 11 patients. Specifically, Dr. Evans has reviewed the contrast sensitivity test results of all of the patients in the Superceding Specification. Based on those scores, and his knowledge of the VectorVision CST and its age-adjusted norms, he will testify that all of the 11 the patients had visually significant contrast sensitivity deficits that were properly recorded on the test forms provided by his company. Based on his own experiments and experience, as well as the peer-reviewed research of others, Dr. Evans will testify that the use of a high glare source, such as the BAT on its highest setting, will not cause a patient with normal, healthy eyes to experience a visually significant drop in Snellen visual acuity or contrast sensitivity as measured by the VectorVision CST, in direct contrast to the State's theory of its case. In short, Dr. Evans will counter the State's theory and evidence that contrast sensitivity and glare testing is not a useful diagnostic tool and rebut the State's contention that Dr. Chase's particular use of the Vectorvision CST was designed to overstate his patients' visual disabilities. He will also describe the significance of each patient's contrast sensitivity test result.

Because he is the developer of the very contrast sensitivity test, test slips, and age-adjusted norms used by Dr. Chase, Dr. Evans will offer testimony that no other witness can provide. Thus, in addition to being highly relevant, Dr. Evans' testimony is non-cumulative.

E. The State Has Attempted To Paint Dr. Chase's Standard Cataract Presentation As Misleading And Pressure-Packed.

At the same time it has attacked his testing methods, the State has presented patient testimony that Dr. Chase's standard cataract presentation was misleading, pressure-packed, and

designed to induce patients to have surgery when they did not need it. The State has specifically identified Dr. Chase's speech to patients regarding "second opinions" and his surgical qualifications as inherently unprofessional. Specifically, the State has elicited testimony from its witnesses that Dr. Chase's informed consent discussion of cataracts and cataract surgery left them feeling rushed and confused. Some of those witnesses have indicated that their questions regarding the surgery went unanswered.² Others claim that Dr. Chase's standard speech regarding second opinions was designed to discourage them from getting second opinions (although most of those patients did, in fact, seek a second opinion, thereby belying their claims). Still others claim that Dr. Chase billed himself as the only doctor in Vermont qualified to perform cataract surgery. Like the other physicians who have testified, Dr. Chase has stated that he gave a nearly identical informed consent presentation to every potential cataract surgery patient.

F. Dr. Chase's Former Patients Will Testify That His Standard Informed Consent Presentation Was Not Improper Or Calculated To Pressure Them Into Cataract Surgery.

Dr. Chase's former patients will offer testimony rebutting these portions of the State's case. While some of the State's complaining witnesses have testified that they felt that Dr. Chase's presentation pressured them into having surgery, the former patients called by Dr. Chase will testify that the very same presentation provided them with all of the information they needed to make an informed and pressure-free decision regarding the propriety of cataract surgery. In short, there was nothing inherently or purposefully improper or coercive in what Dr. Chase told the 11 complaining patients.

² However, every patient who went to see Dr. Chase's nurse, as Dr. Chase requested, testified that they came away with a full understanding of the risks and benefits of cataract surgery. It was only those patients who refused to complete the informed consent process who felt rushed and confused about their surgery decision.

Still other patients will demonstrate that Dr. Chase did not make his cataract surgical recommendations out of an improper motive, as the State contends. These patients will testify that Dr. Chase offered them free care or recommended cataract surgery for which he knew he would never receive compensation. They will confirm that he had only his patients' best interests at heart. As every court and commentator to confront the issue has determined, motive is always relevant because it demonstrates the probability of action. *See, e.g.* Wigmore on Evidence, vol. 1, § 118 (Supp. 2001); *see also United States v. Chas. Pfizer & Co.* 281 F. Supp. 837, 848 (S.D.N.Y. 1968); *People v. Wallace*, 217 N.Y.S. 244 (1926) (because motive shows “the probability of appropriate ensuing action, is always relevant”). But it is particularly so where, as here, the State has specifically accused Dr. Chase of acting out of an “immoral” motive in recommending cataract surgery to his patients against their medical interests. *See* Superseding Specification of Charges, *passim*. The patients to be called by Dr. Chase show that he lacked any such motive and that his sole intent was to provide all of his patients, including the 11 complaining witnesses, with the best possible cataract care, whether or not he was likely to receive a dime in return.

G. Dr. Chase's Former Patients Will Also Demonstrate The Validity Of His CST And BAT, As Well As The Reasonableness Of His Surgical Recommendations To The 11 Complaining Patients.

Dr. Chase's former patient witnesses will also directly address the crux of the State's argument that Dr. Chase fell below the standard of care when he recommended cataract surgery to 11 patients who had early cataracts, good Snellen vision scores, and visual complaints. Dr. Chase's former cataract patients will testify that they experienced disabling real-world visual symptoms, despite the fact that they achieved good Snellen scores when tested in Dr. Chase's office. They will testify that their vision and ability to function in the real world is significantly improved due to their cataract surgery. As noted earlier, under the standard of care as defined by

the American Academy of Ophthalmology, cataract surgery is medically necessary when “cataract surgery provides a *reasonable likelihood of improve[ing]*” a patient’s significant visual problems. *American Academy of Ophthalmology, Preferred Practice Pattern, Cataract in the Adult Eye*, at 15 (2001). Evidence of other former patients’ symptoms, vision scores, treatment recommendations, and results demonstrates the reasonableness of Dr. Chase’s belief that the 11 complaining patients, all of whom had similar symptoms and similarly good Snellen test scores, would also benefit from cataract surgery. Simply put, it was Dr. Chase’s treatment of patients like these that formed the basis for his good-faith (and correct) belief that the 11 complaining patients, too, would benefit from cataract surgery. It is therefore directly relevant to proving that his treatment of those 11 patients met the standard of care, in direct contravention of the State’s explicit allegations.

These patients’ testimony will also directly contradict the State’s contention that Dr. Chase’s CST and BAT overstated his patients’ real-world disability. Like the 11 complaining witnesses, many of the patients to be called as witnesses by Dr. Chase had very poor CST with BAT scores, despite their good Snellen scores. These patients will testify that their poor CST with BAT scores more accurately reflected their real-world visual difficulties, further bolstering the propriety and reasonableness of Dr. Chase’s decision to place reliance on those same scores with respect to the State’s 11 complaining patients.

H. Due Process Requires That Dr. Chase Be Allowed To Present His Expert And Patient Witnesses.

It is not only general rules of relevance that require the Board to allow Dr. Chase’s witnesses to testify. The Constitution demands it as well. As the United States Supreme Court has said, “Few rights are more fundamental than that of an accused to present witnesses in his own defense.” *Chambers v. Mississippi*, 410 U.S. 284, 302 (1973). “The right[] . . . to call

witnesses on one's own behalf [has] long been recognized as an essential to due process.” *Id.* Indeed, this right is “among the minimum essentials of a fair trial.” *Id.* (citing *In re Oliver*, 333 U.S. 257, 273 (1948)(Black, J.)).

It is not enough to simply provide an accused with the right to call some witnesses on his own behalf. Instead, the Supreme Court has repeatedly held that the Due Process Clause requires that an accused “be afforded a meaningful opportunity to present a *complete defense*.” *California v. Trombetta*, 467 U.S. 479, 485 (1984) (emphasis added); *see also Crane v. Kentucky*, 476 U.S. 683, (“the Constitution guarantees criminal defendants ‘a meaningful opportunity to present a complete defense’”); *Holmes v. South Carolina*, 126 S. Ct. 1727, 1731, 1735 (2006) (twice repeating that due process requires opportunity to present a “complete defense”).

Under these rules, an accused cannot be deprived of the opportunity to present exculpatory evidence at trial. *Holmes*, 126 S. Ct. at 1735. Nor can he be prevented from introducing evidence that bears on the credibility of the State’s evidence. *Crane*, 476 U.S. at 690. Rather, all of the State’s evidence must “encounter and ‘survive the crucible of meaningful adversarial testing.’” *Id.* at 691 (quoting *United States v. Cronin*, 466 U.S. 648, 656 (1984).) If a judicial body prevents an accused from presenting multiple pieces of exculpatory evidence, “the cumulative effect of those rulings” may “frustrate[e] his efforts to develop an exculpatory defense.” *Chambers*, 410 U.S. at 290.

These principles, all of which have been articulated repeatedly by the United States Supreme Court over the past 30 years, and reaffirmed as recently as this past spring, absolutely require that Dr. Chase be allowed to present the relevant testimony of his expert and patient witnesses. The State has presented no fewer than six expert witnesses and 11 patient witnesses. It is now attempting to limit Dr. Chase to two expert witnesses (Drs. Freeman and Javitt) and no

patient witnesses. The Board has not prevented the State from eliciting highly cumulative and marginally relevant testimony from its witnesses. Dr. Chase must, at the very least, be allowed to present his highly relevant and non-cumulative expert and fact witnesses. To deny Dr. Chase that opportunity would violate his clearly established constitutional rights and compromise the integrity of these proceedings, to which the Board and the parties have devoted enormous energy and resources. The two extra hearing days necessary to receive this evidence is a small price to pay to protect that investment.

Dated at Burlington, Vermont, this 8th day of December, 2006.

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