

**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	MPD 126-0803
	)	MPC 106-0803	MPC 209-1003
Respondent.	)	MPC 122-0803	MPC 89-0703
	)		MPC 90-0703
	)		MPC 87-0703

DR. CHASE’S OPPOSITION TO THE STATE’S MOTION TO RECONSIDER

Now comes the Respondent, David S. Chase, M.D., by and through counsel, and hereby opposes the State’s Motion to Reconsider.

I. Introduction.

In asking the Board to reconsider its ruling allowing Dr. Chase to present the testimony of his CST and BAT experts and patient witnesses, the State badly misconstrues the nature of its own charges, its own evidence, Dr. Chase’s proffered evidence, and the Board’s stated reasons for allowing him to present that evidence. All of Dr. Chase’s proffered testimony is directly relevant to his treatment of the 11 complaining patients and to rebut the State’s specific allegations and evidence. None of it is so-called “pattern and practice” evidence, as the State contends. Indeed, the Board has repeatedly made clear that it will allow neither side to present such evidence. As a result, there are no valid grounds on which to exclude the testimony of Dr. Evans, Dr. Ginsburg, or the patient witnesses. Similarly, the introduction of their testimony does not justify the expanded rebuttal, and greatly extended hearing, that the State threatens. Finally, if the Board determines that the State will be allowed to present its own pattern and practice evidence in rebuttal, Dr. Chase must be allowed to present his own pattern and practice during his case-in-chief.

II. Discussion.

A. The State Has Cited No Reason For The Board To Reconsider Its Ruling.

“The standard for granting [a motion to reconsider] is strict, and reconsideration will generally be denied unless the moving party can point to controlling decisions or data that the court overlooked - matters, in other words, that might reasonably be expected to alter the conclusion reached by the court.” *Latouche v. North Country Union High School District*, 131 F. Supp. 2d 568, 569 (D. Vt. 2001) (citing *Shrader v. CSX Transp., Inc.*, 70 F.3d 255, 257 (2d Cir. 1995)). “A motion to reconsider should not be granted where the moving party seeks solely to relitigate an issue already decided.” *Id.* Here, the State is asking for nothing more than the opportunity to relitigate the issue it has lost. Indeed, the State does not even bother to argue otherwise.

Accordingly, the Board should refuse to reconsider its prior ruling.

B. The Testimony Of Drs. Evans And Ginsburg Directly Rebutts The State’s Charges And Evidence.

If the Board does re-examine its prior ruling, it should reject the State’s arguments. The State first contends that the testimony of Drs. Evans and Ginsburg is not relevant because “the State has not challenged the use of CST and glare as diagnostic tools” with respect to the 11 complaining patients. (Motion at 2.) The State’s effort at revisionist history runs directly counter to its own Amended Superseding Specification of Charges, in which it specifically alleges that Dr. Chase “improperly measured [his patients’] visual acuity by using the CST with BAT,” (Amended Superseding Specification of Charges ¶ 207), and that his vision test scores were “improperly based on the results of the CST with BAT” and “not on the Snellen Test.” (*Id.* ¶ 50, 96, 291, 323.) It also runs counter to the State’s evidence, which both explicitly and implicitly calls into question the

validity and reliability of Dr. Chase's CST and BAT testing practices as applied to the 11 complaining patients.¹

The State built its case on the mistaken notion that CST and BAT testing is "improper" and that CST with BAT scores are "false." However, at trial the State's own evidence has provided no support for that position. As a result, unless it is to abandon its prosecution, the State has been left with no choice but to change its theory of the case midway through trial. The Board should not allow such a change, and it certainly should not limit Dr. Chase's ability to present exculpatory evidence because it is not "relevant" to the State's newfound theory.

Moreover, the State's newest theory of its case finds no more support in the Superceding Specification or in the evidence presented to date. According to the State, its central allegation is now that "Respondent's use of CST with BAT results" was improperly used to "create[] misleading records to justify his decision to perform cataract surgery." (Motion at 3.)² Of course, the Superceding Specification contains no such allegation. It does not suggest that anyone was misled, or likely to be misled, by Dr. Chase's charting methods. It contains no hint of exactly whom the State now believes might have been misled. In short, the State has not actually charged Dr. Chase with the unprofessional conduct it now states is the main issue in the case.³

Nor has the State proven that anyone was misled, or likely to be misled, by Dr. Chase's

¹ See Respondent's Motion to Present Defense Witnesses for a complete discussion of this point.

² In its Motion, the State also alleges for the first time that Dr. Chase improperly "relied on CST with BAT results to justify his decision to perform surgery on these eleven patients and did not consider or did not perform other visual testing in making his decision." (Motion at 3.) This allegation, too, is absent from the Superceding Specification. More importantly, it is nothing short of pure fantasy when viewed in light of the undisputed evidence that Dr. Chase performed and relied upon more types of vision testing (including an autorefractor, dilated and undilated Snellen testing, automated visual field testing, and CST and BAT) than any other testifying physician in reaching his conclusions regarding cataract treatment.

³ Indeed, in its ongoing efforts to exclude much of Dr. Chase's most powerful evidence, the State has repeatedly stated that it is not alleging that Dr. Chase committed fraud. The State cannot have it both ways: either it believes that Dr. Chase was purposefully misleading others with his charting practices (the very definition of fraud) or not. The Board should require the State to articulate, once and for all, its position on this important issue.

charting practices. All of the evidence presented by the State's own witnesses shows that medical records are designed primarily for the use of the physician and his or her staff. That evidence also makes clear that Dr. Chase, his technicians, and his scribes all understood his charting methods.

It also convincingly demonstrates that no other physicians would be misled by Dr. Chase's charting practices. Every patient's chart contains a Snellen score, normally labeled as such in Dr. Chase's own handwriting. Moreover, whenever Dr. Chase sent a medical record to another physician, he included a chart summary that clearly labeled his CST with BAT scores as such.

Finally, there has been no evidence that insurers ever asked to review the charts of the 11 complaining patients, or that they would be misled by Dr. Chase's methods of charting those patients' CST with BAT scores. To the contrary, Dr. Chase introduced two letters in which he explained his reliance on CST with BAT testing, as well as his CST with BAT charting methods, to CHP, then the State's largest health care insurer. He told Dr. Paul Reiss, CHP's medical director: "Since Snellen vision does not reflect the real-life visual functioning of my [cataract] patients, I use symptoms, visual acuity with CST and glare testing and examination of the cataract with a slit lamp to determine whether or not surgery should be performed. I rarely operate unless visual acuity with CST and glare tests is 20/50 or less." (Resp. Ex. 522 at 2.) He explained to CHP's Quality Improvement Department that, in his charts, "[t]he CST with BAT results are noted beside the vision as a matter of convenience. . . . The test with dates are in the file attached to the front cover of the folder." (Resp. Ex. 523 at 1.) He went so far as to invite Dr. Reiss to serve on his quality assurance committee. (Resp. Ex. 522 at 1.) Thus, any notion that Dr. Chase misled, or intended to mislead, insurance companies is belied by the very evidence introduced during the State's case-in-chief. It is also convincingly refuted by the verdict of the federal jury that unanimously acquitted Dr. Chase of charges that his charts were intended to mislead insurance companies to pay for unnecessary cataract surgery.

In sum, the State's newfound theory of this case finds no support in the State's own charging document or its evidence. To the contrary, it is convincingly refuted by all of the evidence presented to the Board so far. The Board should not exclude Dr. Evans' and Dr. Ginsburg's testimony simply because the State believes that evidence is irrelevant to charges that it has neither brought nor proved. It should allow their testimony because it is directly relevant to the State's actual charges and evidence.

C. The Testimony Of Dr. Chase's Former Patients Is Not Pattern And Practice Evidence, But Is Directly Relevant To Dr. Chase's Treatment Decisions Regarding The Eleven Complaining Patients.

The State next alleges that the testimony of Dr. Chase's former patients is irrelevant to his treatment of the 11 complaining patients, and therefore constitutes improper "pattern and practice" evidence that, if admitted, would justify an enormous expansion of the State's rebuttal case. The State is wrong on all accounts.

As an initial matter, the patients will not simply be describing their "positive experiences" with Dr. Chase, as the State dismissively contends. The former patient witnesses will 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. Many of 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, even though their Snellen scores did not significantly improve. 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.⁴

These patients' testimony will also directly contradict the State's contention that Dr. Chase's CST and BAT scores 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.

The State next makes the cynical, if nonsensical, argument that Dr. Chase will be calling 12 patients in order to "outweigh" the testimony of the State's 11 complaining patients. Only the State could misconstrue the presentation of evidence as a mathematical exercise in which the party with the most witnesses wins. Of course, it is the quality rather than the quantity of evidence that the Board must consider in determining whether the State has met its significant burden of proving its charges by a preponderance of the evidence. Dr. Chase has not, and will not, argue otherwise.

⁴ As a result, this case is crucially different from the "boundary violation" cases that the State cites through analogy.

However, in order to put the State's worries to rest, Dr. Chase may call only 11, or even 10, patient witnesses. The content and quality of their testimony will further disprove the State's theory that Dr. Chase's treatment of the 11 complaining patients was unreasonable and unprofessional.

Dr. Chase will not be using his patient witnesses to "introduce[] the issues of [his] pattern and practice and motive as defenses," as the State contends. Simply put, these patients' testimony will not address Dr. Chase's pattern and practice; it will address the reasonableness of his decisions to offer cataract surgery to the 11 complaining patients. To the extent that same testimony addresses Dr. Chase's innocent motive in offering cataract surgery to his patients, that motive is not a "defense" introduced into the case for the first time by Dr. Chase. Although the State has repeatedly attempted to disclaim any allegations of motive, the Superceding Specification clearly alleges that Dr. Chase purposefully and intentionally offered and performed cataract surgery that he knew his patients did not need, resulting in "immoral" and "dishonest" conduct.

As a result, none of the patients' testimony will "introduce new matters" that justify rebuttal evidence regarding Dr. Chase's pattern and practice. To the contrary, they will directly address issues that the State has made relevant from the outset of this case, and issues on which the State has already introduced voluminous evidence. The State has deleted all of the pattern and practice allegations from its charging document. It purposefully trimmed its case-in-chief to evidence regarding the 11 complaining patients. It must abide by those decisions, even if it is concerned that it has not met its burden of proof. It cannot use Respondent's directly relevant patient testimony as an excuse to greatly expand the scope of its rebuttal case and extend the length of this already expensive and extensive hearing.

Any decision to allow pattern and practice evidence would also necessarily lengthen Dr. Chase's case-in-chief. If the Board were to rule that the State is allowed to present pattern and practice evidence in rebuttal, Dr. Chase would be forced to expand his own case-in-chief to include

true pattern and practice evidence, including the testimony of many additional former nurses, technicians, scribes, and patients. The result would be a hearing more akin to the federal trial, in which nearly 100 witnesses testified over more than 50 days.

III. Conclusion.

The Board was correct to allow Dr. Chase to present the testimony of Drs. Ginsburg and Evans and a handful of patient witnesses to address issues made relevant by the State's charges and evidence. The testimony of those witnesses does not justify an expanded rebuttal case regarding Dr. Chase's pattern and practice of cataract care. The Board should therefore deny the State's Motion to Reconsider and deny the State's request for an expanded rebuttal case. If the Board allows the State to present an expanded rebuttal case, it should allow the Respondent to present all of his own pattern an practice evidence as well.

Dated at Burlington, Vermont, this 29th day of December, 2006.

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