

**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

RESPONDENT'S POST-TRIAL BRIEF

Respondent David S. Chase, M.D., hereby submits the following Post-Trial Brief and the accompanying Proposed Findings in support thereof. Dr. Chase respectfully requests that the Board grant judgment in his favor on each count of the State's Amended Superceding Specification of Charges and adopt the Proposed Findings.

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I. INTRODUCTION.

Based on the complaints of 11 of the approximately 8,000 patients that Dr. Chase examined over the past decade, the State has charged Dr. Chase with the most serious of unprofessional conduct: It alleges that he purposefully recommended and performed surgery that he knew these 11 patients did not need. In leveling this serious charge, and ending Dr. Chase's 37-year career, the State assumed the obligation of presenting serious proof of its allegations. The State has failed to meet that obligation. Instead, the State has systematically attempted to prevent the Board from hearing the evidence it needs to make an informed decision regarding Dr. Chase's conduct. Nonetheless, the overwhelming weight of the evidence, presented by both the State and the Respondent, demonstrates that Dr. Chase provided his patients with the highest quality eye care, utilized the most modern and medically sound practices in diagnosing and treating cataracts, and appropriately provided his patients with a choice of cataract surgery to remedy their cataract-related visual deficits.

The State has not demonstrated that any of the 11 complaining patients was improperly recommended cataract surgery by Dr. Chase. With one exception, the State concedes that every patient had cataracts. Every patient admitted to complaining of visual symptoms. The State has introduced no testimony that the patients' symptoms were caused by something other than their cataracts or that new glasses would have resolved their symptoms.

Although many of those patients chose not to have surgery, Dr. Chase acted professionally when he provided each patient with the choice of surgery if *the patient* decided that her vision no longer met her needs. Three patients chose surgery after being explicitly and repeatedly advised that it was an elective procedure that they should undergo only if they were no longer satisfied with their vision. The remaining eight patients chose not to have surgery, confirming that they understood the elective nature of the surgery. Whether or not the State's

ophthalmologists would have recommended surgery to these patients if they had received the same patient complaints and performed the same tests as Dr. Chase, Dr. Chase's surgical recommendations conformed exactly to the applicable standard of care. No physician has testified to the contrary. Indeed, the State did not even ask its ophthalmologist witnesses to review Dr. Chase's medical records or to opine on the appropriateness of his surgery recommendations. As a result, the Board must rule in Dr. Chase's favor on the State's central claim: Dr. Chase did not act unprofessionally in offering any of the complaining patients the option of cataract surgery.

Nor has the State proven that Dr. Chase falsified his charts in order to justify cataract surgeries. To the contrary, the State's own evidence shows that every patient complaint, test score, and cataract description was properly founded in the results of Dr. Chase's comprehensive evaluation and assessment of his patients and accurately reflected their functional visual deficits. He also properly documented his extensive informed consent process and accurately noted whether or not his patients ultimately chose for or against surgery. Because the State has utterly failed to prove its allegations of falsification, the Board should grant judgment in favor of Dr. Chase as a matter of law on these claims as well.

Finally, the State has not proven that Dr. Chase purposefully discouraged his patients from receiving a second opinion if they desired one. He simply told patients the same thing other physicians did: Any ophthalmologist will tell you that if you see well enough to suit you, you do not need cataract surgery. The evidence shows that every patient who wanted a second opinion sought and received one.

Viewed as a whole, the State's own evidence has shown that Dr. Chase was a very skilled, comprehensive, and dedicated physician. He incorporated important new diagnostic and surgical techniques long before his peers. He conducted more vision testing and patient

education than any other doctor who testified. His informed consent process was uniquely comprehensive and made clear to all of his patients that they should choose cataract surgery only if they felt they were no longer seeing well enough to suit their needs. Simply put, he respected his patients enough to allow them to participate in important decisions regarding their eye care and provided them with the accurate information they needed to make those decisions. The State has utterly failed to demonstrate that these practices were unprofessional. To the contrary, they represent the best that modern ophthalmology can offer patients.

The State has not simply failed to prove its case. It has failed to investigate and prosecute that case consistent with its obligations to the public, the Board, and to Dr. Chase. Over three years ago, the State successfully sought the end of Dr. Chase's career based on the representations of a single patient, Helena Nordstrom, a single technician, Amy Landry, and a single physician, Dr. Patrick Morhun. The fundamental premise of the State's case was, and is, that cataract surgery cannot be justified unless patients have mature cataracts and poor Snellen visual acuity scores, even if they have visual complaints corroborated by contrast sensitivity and glare testing.

Since the summary suspension, the State has learned that Ms. Landry's affidavit was falsified by Phil Ciotti, the Board's investigator. It has learned that Dr. Morhun's expert opinion regarding Ms. Nordstrom was mistaken in many important respects, that Ms. Nordstrom falsified her symptoms to Dr. Morhun, and that Dr. Morhun himself does not feel that Dr. Chase received a "fair shake" at the summary suspension hearing. It has learned that even early cataracts can and do cause visual symptoms warranting cataract surgery, and that contrast sensitivity and glare testing are more comprehensive measures of visual function than Snellen visual acuity, particularly in patients with relatively early cataracts like many of the 11 complaining patients. The State also learned that Dr. Chase and his staff performed the most comprehensive

ophthalmic evaluations in Vermont and provided their patients with an exhaustive informed consent process.

Despite this knowledge, the State has adamantly refused to be shaken from its conclusion that Dr. Chase is a liar and a cheat who put his own interests ahead of his patients. It has exploited the publicity surrounding Dr. Chase's summary suspension in order to identify additional complaining patients, and then charged Dr. Chase with unprofessional conduct toward those patients without even interviewing them first. It has repeatedly attempted to prevent the Board from learning the information that would exonerate Dr. Chase. It has tried to hide its own mistakes, and those of its expert Dr. Morhun, from the Board. It has ignored the overwhelming exculpatory evidence presented by Dr. Chase, apparently hoping that this Board will reflexively affirm the summary suspension decision it reached over three years ago, even as the countervailing evidence accumulates. The State has completely failed, not only to meet its burden of proof, but also to provide the Board with all of the relevant information necessary to a sound decision in this matter. For all of these reasons, the Board must grant judgment in favor of Dr. Chase on all counts.

II. DISCUSSION.

A. The State Has Charged Dr. Chase With Recommending And Performing Unnecessary Cataract Surgery And Falsifying His Charts To Support His Surgical Decisions.

The State has charged Dr. Chase with violating the standards of professional conduct with respect to 11 patients. As to each patient, the crux of the State's allegations is that Dr. Chase improperly recommended or performed cataract surgery. The State does not claim that Dr. Chase mistakenly misdiagnosed his patients, or that he had an honest disagreement with his colleagues. Rather it has charged him with recommending and performing cataract surgery that he *knew* his patients did not need. It also contends that Dr. Chase's surgery recommendations

constituted “willful,” “immoral,” and “dishonest” conduct, in violation of 26 V.S.A. §§ 1354(a)(14) and 1398, because Dr. Chase was allegedly putting his own interests ahead of his patients’ well-being.

The State has also charged Dr. Chase with falsifying his patients’ charts in several different ways in order to support his surgery recommendations. As to six patients, the State alleges that Dr. Chase purposefully “falsified” his patients’ vision test scores because those scores were “improperly based on the results of the CST with BAT” and “not on the Snellen Test,” (*see, e.g.*, Amended Superseding Specification of Charges ¶ 50 (Salatino), 96 (Lang), 291 (McGowan), 323 (Touchette), 384-85 (Kerr)), or that he “improperly measured [his patients’] visual acuity by using the CST with BAT.” (*Id.* ¶ 207 (Corning).) The State does not simply allege that Dr. Chase’s charted vision scores were confusing: It contends that the CST with BAT scores are nothing short of “false.” (*Id.* ¶ 96.) The State alleges that Dr. Chase’s decision to record his patients’ CST with BAT vision also constitutes “unfitness to practice medicine,” and “unprofessional,” “immoral,” and “dishonest” conduct in violation of 26 V.S.A. §§ 1354(a)(8) and 1398.

As to eight of the 11 patients, the State alleges that Dr. Chase purposefully falsified his charts when he described their cataracts as “dense,” even though other physicians described them as early cataracts. (*Id.* ¶¶ 51-52 (Salatino); 100-01 (Lang); 147-48 (Grigas); 200-01 (Corning); 288-89 (McGowan); 318-19 (Touchette); 345-46 (Augood); 382-83 (Kerr).) Once again, the State does not simply allege that Dr. Chase’s method of describing cataracts was potentially confusing to others; it contends that he purposefully falsified those descriptions. The State contends that this, too, constitutes “unprofessional,” “immoral,” and “dishonest” conduct in violation of 26 V.S.A. §§ 1354(a)(8) and 1398.

With respect to 4 of the 11 patients, the State contends that Dr. Chase purposefully falsified their visual complaints in his records. (*Id.* ¶¶ 91-92 (Lang), 144 (Grigas), 321 (Touchette), and 380 (Kerr).) Although each of these four patients admitted under oath that they were experiencing visual symptoms, and those symptoms are corroborated by Dr. Chase's vision testing, the State faults Dr. Chase for recording his own conclusions regarding the patients' symptoms, rather than exactly what the patients now recall saying to Dr. Chase about their symptoms some four to eight years ago.

The State claims that yet four other patients' records contain false entries that the patients wanted their cataracts removed, when in fact they chose against having surgery. (*Id.* ¶¶ 204 (Corning); 321 (Touchette); 347 (Augood); 380 (Kerr).) The State also asserts that Dr. Chase falsified his records when his technicians wrote "second opinion given" as part of their summary of Dr. Chase's own informed consent process. (*Id.* ¶ 6 (Nordstrom), 53 (Salatino), 104-05 (Lang); 145-46 (Grigas); 202-03 (Corning); 292-93 (McGowan); 324-25 (Touchette); 347-48 (Augood); 386-78 (Kerr).) Yet again, the State does not just allege that this shorthand notation was potentially confusing. The State instead explicitly but nonsensically alleges that this entry falsely indicates that Dr. Chase's patients "received a second opinion from another physician as to [his patients'] need for cataract surgery." (*Id.* ¶ 292, 324, 386.)

Finally, the State contends that Dr. Chase improperly discouraged four patients from receiving a second opinion regarding cataract surgery. (*Id.* ¶¶ 5, 26 (Nordstrom), 103, 116, 132 (Lang), 343, 358 (Augood), 378, 391, 401 (Kerr).) This allegation is based on a similarly nonsensical interpretation of Dr. Chase's standard informed consent presentation. It also ignores the undisputed fact that three of these four patients all sought and received a second and third opinion before deciding against surgery, and that the fourth understood that she should only have surgery if her vision no longer suited her needs.

The State has not charged Dr. Chase with chart falsifications other than those outlined above. For instance, it has charged that he improperly recorded his physical findings, patient complaints, or vision test scores in the “wrong” sections of his charts. It has not charged Dr. Chase with any unprofessional conduct arising out of his decision to accurately inform his patients of his surgical qualifications or his membership in the American College of Eye Surgeons. It has not charged him with coercing patients into receiving cataract surgery that they did not want. The State is bound by these limitations in the Amended Superceding Specification of Charges, and the Board can only consider the charges that the State has explicitly asserted.

B. The State Has The Burden Of Proving Each Of Its Allegations By A Preponderance Of The Evidence.

Dr. Chase is presumed innocent of all of the charges of unprofessional conduct the State has leveled against him. He does not need to disprove them in order to prevail. Instead, the State bears the burden of proving each of its allegations by a preponderance of the evidence. *See Huddleston v. University of Vermont*, 168 Vt. 249, 252 (1998). In order to find that the State has met its burden, the Board must conclude that Dr. Chase more likely than not engaged in the “immoral,” “dishonest,” and “unprofessional” conduct specifically alleged. Thus, “if the conflicting evidence of the parties is of equal weight, or if the evidence of the [physician] outweighs that of the [State], the evidence of the [State] does not preponderate,” and the Board must find in favor of Dr. Chase. *In re Muzzy*, 141 Vt. 463, 473 (1982). In short, if the Board finds that it is more likely than not that Dr. Chase did not act in an immoral, dishonest or unprofessional manner, it must reject the State’s charges. Similarly, if it does not have sufficient information to decide any of the charges against Dr. Chase one way or the other, it must rule in his favor as well. In making its decisions, the Board must take account of all of the testimony and exhibits presented by both parties.

C. According To The Government’s Evidence, It Is Appropriate To Offer A Patient Cataract Surgery If A Cataract Is Compromising The Patient’s Vision, Cataract Surgery Offers A Reasonable Likelihood Of Improving The Patient’s Vision, And Glasses Will Not Solve The Patient’s Vision Problems.

The parties agree that American Academy of Ophthalmology’s Preferred Practice Pattern (“AAO PPP”) contains the standard that an ophthalmologist must apply when deciding to offer cataract surgery. 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 reasonable likelihood of improvement.” (Respondent’s Proposed Findings of Fact and Law (“PF”) ¶ 91.) The AAO PPP also states that it is inappropriate for a doctor to offer cataract surgery to a patient if the doctor concludes that a new glasses prescription will adequately address the patient’s visual problems, even if they are caused by a cataract. (PF ¶ 93.)

Through its questions and argument at the hearing, the State has suggested that it violates the AAO PPP for a doctor to *offer* a patient the choice of cataract surgery unless *the doctor* concludes that the patient’s vision no longer meets her needs. Both the AAO PPP and every doctor to testify have roundly rejected this nonsensical position. Because the AAO PPP’s standard for cataract surgery depends on the patients’ subjective evaluation of their own visual problems, the State’s physician witnesses agree that only the patient can decide when her visual symptoms are bad enough that she is willing to undergo cataract surgery to remedy them. Those same State witnesses concur that a patient cannot decide whether her symptoms are sufficiently bad to justify surgery *until* the physician offers cataract surgery to her and explains all of the potential risks and benefits involved. (PF ¶¶ 95-98.)

As a result, a physician does not need to decide whether the patient’s vision is no longer meeting her needs before offering her the choice of cataract surgery, along with all of the information regarding risks and benefits that the patient needs to make her own surgical decision.

Instead, according to every physician who testified, it is appropriate for an ophthalmologist to provide a patient with the choice of cataract surgery when: (1) the patient has cataracts; (2) the patient complains of visual impairments that the doctor attributes to the cataracts; (3) glasses are unlikely to resolve the symptoms; and (4) cataract surgery offers a reasonable likelihood of improvement. (PF ¶ 97.) The patient may then decide to have surgery, or not, depending on her own visual needs and symptoms and taking into account all of the potential risks and expected benefits of the surgery. (PF ¶ 95.) The fact that a patient decides that her lifestyle is not sufficiently compromised by her vision, and therefore chooses not to have cataract surgery, does not render the physician's offer or recommendation of surgery inappropriate. (PF ¶ 100.) The State is fundamentally mistaken in arguing, against the weight of its own witnesses' testimony and contrary to common sense, that prior to offering or recommending surgery, a doctor must determine that his patient's lifestyle is sufficiently compromised that she will decide to undergo the surgery.

Also contrary to the State's position, a patient does not need to wait until her cataracts entirely prevent her from doing what she wants or needs to do before having surgery. Instead, it is enough that the cataracts have made those tasks more difficult or "less comfortabl[e]." Those tasks can be occupational or recreational, as long as they are important to the patient. (PF ¶¶ 92, 99.)

Notably, the standard for offering patients cataract surgery contains no requirement that the patient's vision scores—whether Snellen or contrast sensitivity—fall below a certain level. (PF ¶¶ 104-05.) Although some ophthalmologists still employ an outdated Snellen cutoff in determining when surgery is appropriate, (PF ¶ 110), the AAO has abandoned any such threshold, and modern cataract surgeons do not employ one. For instance, two of the State's most important ophthalmologist witnesses, Drs. Tabin and Cavin, both testified that it is

appropriate to perform cataract surgery on patients who have 20/20 Snellen visual acuity, as long as they are being bothered by other symptoms, such as glare or poor contrast sensitivity, caused by the cataract. (PF ¶ 106-07.)

Similarly, the standard for offering cataract surgery contains no requirement that a cataract reach any particular level of physical opacity, ascertainable by slit lamp examination, before surgery is appropriate. (PF ¶ 102.) A physician cannot tell how a cataract will affect a patient's vision simply by viewing the cataract through the slit lamp. As Dr. Javitt testified, it has been proven "beyond a shadow of a doubt" through peer-reviewed scientific studies that the slit lamp impression of a cataract is "utterly useless" in determining how much visual disability the cataract is causing and whether surgery is needed. (PF ¶¶ 103-04.) The recently-published Beaver Dam Study, introduced by Respondent and entirely ignored by the State, proves what the drafters of the AAO PPP and modern cataract surgeons have known for years: very early cataracts, even those rated less than 1 on a four-point grading scale, are capable of causing significant visual symptoms. (PF ¶ 104.) Although those symptoms are not always accompanied by a decrease in Snellen visual acuity (but are often reflected in reduced CST scores), they can be remedied through cataract surgery. (PF ¶ 104.)

D. The Physician Can Identify A Cataract Through Several Means.

Every physician, including Dr. Chase, testified that, prior to making any decision regarding cataract surgery, a physician must detect a cataract in his patient's eye(s) via a physical examination. (PF ¶ 36.) Most cataracts, particularly those that result in discoloration of the lens, are discernable through a slit lamp examination of the patient's lens through a dilated pupil. Conversely, it is impossible to rule out the existence of a cataract without first dilating the patient's eyes. (PF ¶ 37.)

According to the AAO PPP and many of the doctors that testified, other cataracts are difficult to discern through a dilated slit lamp examination because they consist of disturbances in the optical quality of the lens, rather than discoloration. (PF ¶ 38.) As a result, a physician can often discern a cataract only through other means, such as retroillumination produced by a direct or indirect ophthalmoscope, or through the use of a specialized instrument that measures the disturbance of light rays as they pass through the lens. (PF ¶ 38.) A slit lamp cannot produce the type of retroillumination helpful in the identification of these cataracts. If a physician does not use retroillumination, he may not identify these lens disturbances, even visually significant ones. (PF ¶ 38.)

Honest and competent doctors occasionally fail to see cataracts during their physical examination, either because they fail to utilize retroillumination or because their attention was directed elsewhere during the course of the examination. (PF ¶ 172.) Moreover, while the AAO PPP states that a cataract consists of any degradation in the optical quality of the lens through loss of clarity or change in color, honest and competent doctors sometimes disagree about when a lens disturbance constitutes a cataract. (PF ¶¶ 179-82.) When asked when he considers a “trace opacity” to be a cataract, Dr. Irwin replied: “It depends on the day.” (PF ¶ 179.) In assessing whether the complaining patients had cataracts, the Board is not bound by the idiosyncrasies of the State’s testifying ophthalmologists: It is bound by the AAO PPP.

E. Physicians Have A Number Of Legitimate Tools To Help Them Assess The Visual Significance Of A Patient’s Cataracts.

If a cataract is detected upon physical examination, the doctor must next assess whether that cataract is of visual significance to the patient. The patient history is the first means by which a physician can make this assessment. A physician can take patient histories through patient interviews, patient questionnaires, or both. (PF ¶ 39.) Cataract-related symptom

questionnaires are often the best measure of patients' visual function prior to cataract surgery, and have been proven to be much more reliable than the patients' post-surgical recollection of pre-surgical symptoms. (PF ¶ 44.) Doctors have available many types of such questionnaires: The Lifestyle Questionnaire used by Dr. Chase is based on a peer-reviewed questionnaire published in the Archives of Ophthalmology and a questionnaire published by the American Society of Cataract and Refractive Surgeons for use by its members. (PF ¶ 43.)

All of the doctors and testifying physicians recorded their conclusions regarding their patients' symptoms in the history sections of the patients' charts, whether the symptoms were revealed during the initial patient interviews or later during the course of the doctors' examinations. (PF ¶ 45.) It is acceptable for doctors to paraphrase their patients' complaints. It is also acceptable, indeed important, for physicians to record their own conclusions regarding their patients' visual disabilities based on their physical examinations and visual testing, even if the patient does not recognize or admit that the visual disability exists. (PF ¶¶ 45-47.) For instance, if an ophthalmologist concludes based on his visual testing that a patient is unsafe to drive at night, he has an obligation to record that visual deficit in the patient's chart, whether or not the patient agrees with the conclusion. (PF ¶ 47.) However obtained and recorded, the patient's symptoms are the most important component of cataract diagnosis, evaluation, and treatment.

F. Physicians Also Use Vision Testing To Identify And Assess The Significance Of Cataract-Related Visual Symptoms.

It is well-documented that, due to the insidious development of cataracts, patients often do not recognize cataract-related vision loss. (PF ¶ 40.) Many patients who do recognize cataract symptoms are reluctant to admit those symptoms to their physician—often because they are afraid of losing driving privileges or are fearful of cataract surgery. (PF ¶ 40.) Because

patients do not always recognize or complain of visual loss due to cataracts, physicians have at their disposal a number of different vision tests that help them assess the functional significance of their patients' cataracts. (PF ¶ 50.)

Most of the physician witnesses, including Dr. Chase, evaluated their patients' best corrected Snellen visual acuity—the ability to discern high-contrast black letters and numbers on a white background under ideal lighting conditions consisting of a dim room with a lighted vision chart. (PF ¶ 51.) The undisputed evidence demonstrates that Dr. Chase's office measured his patients' best corrected Snellen vision three separate times during each examination: once through use of an autorefractor, once by the technician making manual refractive measurements prior to dilation, and once by Dr. Chase, who manually re-refracted each patient after dilation. (PF ¶¶ 119, 120, 128.)

Unfortunately, cataracts cause a variety of disabling symptoms that are unrelated to the loss of high-contrast visual acuity that is measured by the Snellen chart. (PF ¶¶ 30, 31, 51.) For instance, due to their light scattering effect, cataracts often cause patients to experience a significant reduction in their contrast sensitivity—the ability to distinguish between objects of varying shades and luminescence, long before they experience a significant reduction in their Snellen vision. (PF ¶¶ 60-63.) As a result, cataracts can cause objects to appear “washed out” even though they are in focus and therefore not blurry. Reduced contrast sensitivity caused by cataracts is most likely to affect a patient's ability to see in dim light or bright light, or to distinguish objects of similar contrast under any lighting conditions. (PF ¶¶ 60-63.) For instance, reduced contrast sensitivity can make it difficult for cataract patients to drive at night, or to distinguish where one stair tread ends and another begins. (PF ¶¶ 60-63.) In addition, cataracts are notorious for causing patients symptoms of glare in challenging lighting conditions, such as driving at night and being outside on a sunny day. (PF ¶ 65.) These symptoms, too, are

unrelated to optical blur measured by high-contrast Snellen testing in a darkened examination lane.

Thus, while evaluating Snellen visual acuity is important for determining whether patients have the best possible corrective lenses, it does little to test how a patient sees in the real world, where objects are of varying sizes and shades of luminescence and contrast and must be viewed under a variety of lighting conditions. (PF ¶ 51.) As a result, Snellen testing is often not helpful in detecting or assessing many of the real life visual symptoms caused by cataracts, including glare and loss of contrast sensitivity. (PF ¶ 51.) The AAO PPP states that it is appropriate for a doctor to perform contrast sensitivity (“CST”) and glare testing in order to overcome the shortcomings of Snellen vision testing with respect to cataract patients. “Contrast sensitivity function and glare disability may be tested to measure vision loss and visual disability due to glare and loss of contrast sensitivity.” (PF ¶¶ 59, 65.) According to the PPP, glare testing can provide 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.

(PF ¶ 65.) Every doctor witness agreed. (PF ¶ 65.)

The AAO PPP also states that contrast sensitivity testing is a “more comprehensive” way to detect loss of functional vision due to cataract than is Snellen visual acuity testing:

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].***

(PF ¶ 59 (emphasis added).)

CST results have been proven to correlate more closely with patients' self-described cataract symptoms than do Snellen visual acuity scores; CST scores are also a better predictor than Snellen visual acuity scores of the likelihood of being the at-fault driver in an auto accident or suffering a fall; CST correlates better than Snellen visual acuity with many important real-life visual tasks, such as seeing road signs, seeing to drive safely at night, and discerning stairs. (PF ¶¶ 59-63.) The Beaver Dam Study demonstrates that early lens opacity diminishes contrast sensitivity and causes significant visual impairments long before it affects Snellen visual acuity. As a result, CST is a better measure than Snellen acuity of visual disability caused by cataracts, and by early cataracts in particular. (PF ¶¶ 59-63.)

Although all of the evidence available to the panel confirms that contrast sensitivity and glare testing are a more comprehensive and sensitive measure of many patients' decreased visual function due to cataracts, Dr. Chase is the only testifying doctor who performed CST and BAT on every one of the complaining patients. While Dr. Irwin and Dr. Morhun performed glare testing on three of the 11 patients (confirming significant glare disabilities in two, even using a high contrast Snellen chart and simulating lighting conditions on a partly cloudy day), no other doctor performed glare or CST to help assess the significance of the patients' cataracts or their visual complaints.

G. The Undisputed Evidence Shows That Dr. Chase Acted Appropriately In Offering His Patients The Choice Of Cataract Surgery.

The undisputed, and indisputable, evidence shows that Dr. Chase was justified in offering cataract surgery to every one of the 11 patients. First, every patient had cataracts. Second, every patient had visual complaints associated with those cataracts. Third, every patient had a significant contrast sensitivity deficit demonstrated through objective testing. Fourth, glasses would not address the patients' symptoms. Finally, all of the patients were provided an informed

consent process that made clear the elective nature of the recommended surgery and confirmed that surgery was appropriate only if their vision no longer met their needs. As a result, Dr. Chase's surgery recommendations were proper, whether or not the patients chose to go forward with the elective surgery. Each patient is discussed separately and at length in the Proposed Findings filed herewith. A summary of that discussion is set forth below.

1. With A Single Exception, The State Concedes That The Complaining Patients Had Cataracts.

With the exception of Ms. Nordstrom, who is discussed separately below, all of the complaining patients had cataracts according to the State's own doctors. (PF ¶ 232.) Although some of the physician witnesses testified that the patients' cataracts were not advanced, or labeled them nuclear scleroses rather than cataracts, each physician testified that the 10 patients had a cataract, defined to mean a "degradation in the optical quality of the crystalline lens through loss of clarity or change in color."

2. All Of The Patients Were Experiencing Visual Symptoms When They Saw Dr. Chase.

To a person, each of the 11 patients admitted that he or she was experiencing visual symptoms at the time of Dr. Chase's surgery recommendations. In some instances, the patients' complaints were recorded by Dr. Chase's technician at the outset of the examination. In others, the patients themselves recorded their symptoms on patient questionnaires. In still others, Dr. Chase recorded additional patient symptoms after examining and speaking with the patients. Moreover, in each case, the patients *admitted under oath* that they were suffering visual symptoms at the time they saw Dr. Chase. (PF ¶¶ 233-37.)

Helena Nordstrom complained that the vision in her left eye had become constantly blurry and was causing her difficulty reading road signs and driving at night, among other things. She admitted to all of these symptoms at the hearing. (PF ¶¶ 267, 269-72.)

Dr. Chase's technician recorded that Frank Cole complained that he was bothered by lights and was fearful when driving at night. (PF ¶ 483.) At the hearing, Mr. Cole admitted to being fearful of not being able to see animals and other objects when he was driving. He also testified that he was bothered by glare when light reflects off of wet roads. (PF ¶ 483.)

On her Eye Health History form, Susan Lang wrote that she indicated that she was "currently experiencing" halos and was "bothered by glare." (PF ¶ 376.) She also complained to Dr. Chase that she was having newfound trouble seeing a small scientific instrument at her work and that she was bothered by the bright lights that she used in order to see that instrument. (PF ¶ 377.)

Dr. Olson complained to Dr. Chase's technician that his near vision had decreased, he was bothered by glare, and he tried to avoid driving at night because of his vision. He informed Dr. Chase that he retired in 1993 because he noticed his vision was decreasing and he was concerned he might miss something, especially on x-rays. He also testified that he had difficulty reading his cello music in the dim light of the orchestra pit and may have discussed that with Dr. Chase. (PF ¶ 424.)

Margaret McGowan told Dr. Chase that she saw "starbursts" around lights when driving at night and "had trouble seeing with cars coming at [her] at night." She filled out an Eye Health History form, in which she indicated that she was "currently" being "bothered by glare." (PF ¶ 508.) Ms. McGowan also completed a Lifestyle Questionnaire, on which she indicated that her sight "sometimes" made it a "problem" to see traffic signs, read newspapers, and work at her job, among other things. She also reported that she was sometimes "bothered by" poor night vision, glare, hazy or blurry vision, and seeing in poor or dim light. Finally, she reported that problems with her sight always caused her to be "fearful" when she drove during evening or night hours. (PF ¶ 509.)

Jane Corning indicated on her eye health history form that she was bothered by glare, and she told Dr. Chase's technician that she was bothered by glare when driving on wet roads at night. (PF ¶ 441.)

Mr. Touchette was having difficulty reading the computer screen, trouble with intermediate and near vision, and "had to work to see things clearly." (PF ¶ 535.)

Jan Kerr reported that she noticed a decrease in both her near and far vision, was having difficulty seeing fine print, was having difficulty seeing small and fine objects (such as sutures) in the operating room when the lights were dimmed (as they often were), and was having difficulty seeing to drive at night because of glare. (PF ¶¶ 590-91.)

When the technician took his history, William Augood told her that he was having some trouble with glare on bright days. When filling out his own Eye Health History form, Mr. Augood indicated that he was currently "bothered by glare." He confirmed these symptoms when testifying under oath at the merits hearing. (PF ¶ 564.)

Judith Salatino wrote in her own hand that she was bothered by glare and floaters, that her vision sometimes made it a problem for her to read small print, see traffic signs and see steps, and that she was sometimes bothered by poor night vision, seeing rings around lights, glare, hazy or blurry vision and seeing in poor or dim lighting. (PF ¶ 332.)

Finally, Ms. Grigas told Dr. Chase that she had difficulty driving at night, had darker vision in general, and that she was bothered by glare. (PF ¶ 406.) She then completed and signed a form stating that she had decided to have cataract surgery because: 1) she was bothered by glare; 2) she had trouble seeing in poor or dim light and driving at night; and 3) she was concerned about driving. These complaints, described by the patients under oath and also documented in their medical records, amply demonstrate that the patients were symptomatic. (PF ¶ 410.)

3. In Each Case, The Nature And Extent Of The Patients' Visual Symptoms Were Confirmed By Dr. Chase's CST And BAT.

Dr. Chase performed CST and BAT on all of the 11 patients. Upon testing, each patient exhibited a serious contrast sensitivity deficit as compared to the age-adjusted norms set by the manufacturer of Dr. Chase's VectorVision testing unit and recording slips. VectorVision has carefully calculated normal CST score ranges for individual age groups; those normal ranges include 95% of the population. If a patient falls below the normal range for her age, she is in the bottom 2.5% of the population. The complaining patients fell 40% to 80% below the very *bottom* of the normal range for their age, meaning that their CST scores well within the bottom 1%. (PF ¶¶ 275, 333, 378, 406, 425, 443, 484, 509, 538, 567, 594.) As noted above, the undisputed evidence shows that reduced contrast sensitivity is a common cataract symptom and causes significant real-life visual disabilities, such as trouble seeing in poor or dim light, trouble driving at night, and difficulty seeing in bright conditions, such as sunshine, oncoming headlights, and streetlights – the very symptoms of which these patients complained.

4. The State Has Introduced No Evidence That The Patients' Symptoms, Or Their Low CST And BAT Results, Were Caused By Anything Other Than Their Cataracts Or Could Be Remedied With Glasses.

As noted above, according to the State's own evidence, the complaining patients had cataracts and visual symptoms. Dr. Chase testified that, as to all 11 patients, he ruled out other possible causes of their symptoms, including uncorrected refractive error – such as nearsightedness, farsightedness, and astigmatism -- and attributed their visual problems to their cataracts. (PF ¶¶ 266-617.) Dr. Freeman, who reviewed all of the patients' charts from all of their eye doctors, agreed. (PF ¶¶ 266-617.) The State suggests that the patients' cataracts did not cause their problems. However, it has not introduced any actual evidence that the complaining patients' visual symptoms were caused by something else. This omission is fatal to

the State's allegations. Because Dr. Chase is presumed innocent, and because the State bears the burden of proof, it must demonstrate to the Board that Dr. Chase was wrong when he concluded, based on 37 years of experience diagnosing and treating eye disease and decades of following the same patients, that their symptoms were caused by their cataracts, rather than something that could be addressed through non-surgical intervention, such as new glasses. The simple fact is this: The State has introduced no testimony, expert or otherwise, that the complaining patients' symptoms were the result of uncorrected refractive error that could be addressed with new spectacles. Dr. Freeman, the only ophthalmologist to review all of the records for each patient—whether generated by Dr. Chase or the second opinion doctors—testified that cataracts were the only potential cause of any of the patients' symptoms or low CST with BAT scores. (PF ¶¶ 266-617.)

Indeed, all of the available evidence shows that new glasses would not have alleviated the patients' symptoms. None of the patients had a significant change in their glasses prescription, whether determined by Dr. Chase or the second opinion ophthalmologists. (PF ¶¶ 266-617.) Dr. Chase's CST and BAT was performed after the patients were refracted and had been given their best possible correction. (PF ¶¶ 266-617.) As a result, the significant contrast sensitivity and glare deficits exhibited by the complaining patients upon testing were the product of their best possible corrected vision and by definition could not be improved with glasses. Notably, none of the State's physician witnesses attempted to improve the patients' glare vision or contrast sensitivity with new glasses, and therefore cannot take issue with Dr. Chase's conclusions. The State's unsupported arguments aside, the Board has no evidentiary basis on which to conclude that the patients' symptoms, or the contrast sensitivity and glare deficits, would have been addressed through means other than surgery.

5. Dr. Chase's Informed Consent Process Was Second To None In Its Effectiveness.

Only three of the 11 complaining patients actually had surgery: Ms. Salatino, Ms. Lang, and Ms. McGowan. The material facts surrounding their surgeries are as clear as they are undisputed. Ms. Salatino, Ms. Lang, and Ms. McGowan all had cataracts and visual symptoms. They all received an extensive informed consent presentation, begun by Dr. Chase and completed by his nurses, during which they were advised that they should only have cataract surgery if they felt they could no longer function adequately because of their sight. They all testified that they understood that it was their choice to have surgery or not, based on their own visual needs and symptoms. Yet they all chose surgery nonetheless. No physician has opined that those surgeries were unnecessary.

Each patient participated in an extensive informed consent process before being scheduled for cataract surgery – a process made possible by the fact that Dr. Chase owned his own ambulatory surgical center and could therefore design his informed consent process to serve his patients' needs, rather than the needs of a hospital. After Dr. Chase summarized the risks and benefits of surgery to his patients, a registered nurse completed the informed consent presentation. (PF ¶¶ 193, 201.) Although there was no requirement that the counseling be performed by a trained nurse, Dr. Chase always hired RNs for the position. (PF ¶ 201.) Dr. Chase considered the nurse's informed consent presentation as an integral part of his examination. (PF ¶ 221.) The counseling nurse spent between one and 1.5 hours with each patient, describing cataracts and cataract surgery, reviewing the risks and benefits of surgery, and taking pre-operative measurements of the patients' eyes. (PF ¶ 204.) Other doctors' informed consent processes took between 5 and 10 minutes. (PF ¶ 205.)

Dr. Chase’s nurse provided patients with a four-page informed consent document and reviewed it with them. Among other things, the informed consent document told patients:

Except for unusual problems, a cataract operation is indicated only when you feel you cannot function adequately due to poor sight produced by a cataract, which is a cloudy natural lens inside the eye. The natural lens within your own eye with a slight cataract, although not perfect, has some advantages over any man-made lens. You and Dr. Chase are the only ones who can determine if or when you should have cataract operation – based on your own visual needs and medical considerations, unless you have an unusual cataract that may need immediate surgery.

....

This is usually an elective procedure, meaning you do not have to have this operation.

(PF ¶ 209 (emphasis added).) Dr. Chase’s informed consent document is far more comprehensive than the generic forms used by all ophthalmologists who perform surgery at Fletcher Allen. (PF ¶ 210.) Unlike nearly every other doctor who testified, Dr. Chase did not require his patients to sign the informed consent form on the day they scheduled the surgery. Instead, he asked every patient to take the document home, review it, discuss it with family, and call with any follow-up questions. The patients were only required to sign the informed consent document on the day of surgery, after all of their questions were addressed. (PF ¶ 211.)

Surgical patients were also provided with educational cataract pamphlets pre-printed by the American Academy of Ophthalmology, the largest and most mainstream organization of ophthalmologists. That pamphlet informed patients: “With few exceptions, the presence of a cataract will not harm your eye Many people have cataracts but can still see well enough to do the things they enjoy. ***The decision is up to you.***” (PF ¶ 212 (emphasis added).)

If, as the State contends, Dr. Chase was bent on coercing his patients into undergoing surgery they did not need, the Board would expect the State to have provided evidence that Dr.

Chase abused his independence from Fletcher Allen or other hospitals to give short shrift to the informed consent process. Instead, the evidence convincingly demonstrates just the opposite: Dr. Chase's informed consent process was far more comprehensive than that utilized at Fletcher Allen or by any of the State's testifying ophthalmologists, and made clear to his patients that cataract surgery was their choice, depending on their own visual needs and symptoms.

6. The Surgical Patients Affirmatively Decided That They Were No Longer Seeing Well Enough To Suit Their Needs And Chose Cataract Surgery After Learning All Of The Risks And Benefits.

All three surgical patients testified that the informed consent process provided them with the information they needed to make an intelligent decision regarding surgery. Ms. Salatino was already familiar with much of the informed consent process from participating in her husband's informed consent teaching two years before, when Dr. Chase performed successful cataract surgery on him. (PF ¶ 337.) She understood from the informed consent form and the pamphlets that the decision whether to have the surgery was hers to make, that she should not have the surgery unless the cataract was preventing her from doing something she wanted or needed to do, and that waiting to have the surgery until she was comfortable with it would not compromise the outcome. (PF ¶¶ 337-38.) Ms. Salatino said that she used the five weeks between her informed consent teaching and the surgery to consider whether her vision was still meeting her needs. (PF ¶ 340.) After this period of reflection, she decided to proceed with the surgery.

Similarly, after completing the informed consent process, Ms. Lang understood that cataract surgery was elective, that is was only indicated if she felt she could not function adequately due to poor sight produced by a cataract, and that she should not have the procedure unless she was seeing poorly enough. (PF ¶¶ 384, 386.) Ms. Lang was familiar with informed consents by virtue of prior surgeries and through her job overseeing human research studies. (PF ¶ 385.)

Ms. McGowan also understood that the decision about cataract surgery was hers to make based on her own perception of her visual needs and deficits and that she should only have surgery if she felt her vision was no longer meeting her needs. (PF ¶ 514.) In short, all three surgical patients testified that they understood the nature of their choice, and that they should decline surgery if they felt they were seeing well enough without it. Yet all three chose surgery nonetheless, and all had excellent surgical outcomes.

It is difficult to imagine a set of facts—all confirmed by State witnesses—that more powerfully demonstrate that Dr. Chase’s surgical patients all had “vision that no longer [met] their needs and for which cataract surgery provid[ed] a reasonable likelihood of improvement,” as required by the American Academy of Ophthalmology. Notably, not a single doctor has testified that Dr. Chase was wrong to operate on these patients. They specifically disclaimed any opinion on that topic. (PF ¶¶ 344, 393, 518.) On this basis alone, the Board must rule that Dr. Chase’s decision to perform surgery on Ms. Salatino, Ms. Lang, and Ms. McGowan conformed to professional standards.

7. Dr. Chase’s Recommendations To His Non-Surgical Patients Also Conformed To The Highest Standards Of Professionalism.

The remaining eight patients chose not to have surgery, even though Dr. Chase recommended it as treatment for their cataract-related visual symptoms.¹ Dr. Chase requested that all of these patients go through the same informed consent process described above. (PF ¶¶ 193, 201.) Some did, and decided against surgery after learning all of the risks and benefits. Others decided against surgery before completing the informed consent process. The State has argued that because these patients declined Dr. Chase’s recommendation of surgery, their visual

¹ As discussed below, Dr. Chase did not even offer surgery to Dr. Donald Olson, even though it would have been appropriate treatment for his visually significant cataracts.

problems were not sufficiently severe and he was therefore wrong to recommend it. The evidence presented by the State does not support its arguments.

Because cataract surgery is an elective procedure, the propriety of which depends in large part on the patients' own assessment of her symptoms, it is not uncommon for patients to decide after completing the informed consent process that the low risks of cataract surgery outweigh its expected benefits. Thus, the fact that a patient ultimately decides against elective surgery does not render the physician's recommendation unprofessional. (PF ¶ 100.) In fact, a patient cannot intelligently choose to have surgery, or not, until the ophthalmologist offers it and describes the risks and benefits. (PF ¶ 96.) As discussed above, all of the patients had cataracts and cataract related symptoms that could not be remedied through glasses. Dr. Chase therefore properly recommended surgery to fix their problems, if they desired. The fact that 8 of the 11 complaining patients chose not to have surgery forcefully demonstrates that Dr. Chase's informed consent process provided his patients with a real choice and was not designed to coerce them into having surgery that they did not need or want.

H. The Fact That Other Physicians Did Not Offer The Complaining Patients Cataract Surgery Does Not Demonstrate That Dr. Chase Acted Unprofessionally In Doing So.

In the face of this evidence, the State has offered the testimony of doctors who disagree with Dr. Chase's surgical recommendations based on their own examinations of the patients, often performed months or years later. It has offered no expert testimony that Dr. Chase's surgical recommendations were unprofessional based on all of the information available to him at the time, including the patients' CST/BAT scores. This failure of proof alone requires judgment in favor of Dr. Chase on the State's central claims of unnecessary surgery for a number of independent reasons.

First, according to the State's own experts, competent and honest physicians can disagree as to when cataract surgery is appropriate for a particular patient. (PF ¶ 108.) Dr. Chase has admitted, and the State's physician witnesses agreed, that the State's ophthalmologists were relatively more conservative in recommending surgery. Some of the State's ophthalmologist witnesses even admit to applying a standard different, and more conservative, than the AAO PPP. For instance, Dr. Guilfoyle testified that he will never recommend cataract surgery to a patient who sees better than 20/30 and rarely offers it to a patient who sees 20/40, even though the AAO PPP contains no such requirement. (PF ¶ 110.) As in any area of medicine, both aggressive and conservative styles of treatment can coexist within professional boundaries. In order to determine whether the State has proved that Dr. Chase acted unprofessionally in offering and/or performing cataract surgery, the Board must compare Dr. Chase's recommendations to the AAO PPP standard, taking into account all of the information that was available to him at the time he examined the patients.

Second, the information available to the second opinion doctors differed from the information available to Dr. Chase. Many of the complaining patients provided their second-opinion doctors with materially different visual complaints than they provided to Dr. Chase and his technicians, often in their own handwriting. (PF ¶¶ 266-617.) For instance, Ms. Salatino told Dr. Chase and his technicians on multiple occasions over several years that she was being bothered by glare and was having trouble driving at night; in stark contrast, she told Dr. Morhun that she had not been experiencing any trouble driving at night. (PF ¶¶ 329, 330, 332, 354.) The patients admitted these discrepancies at the hearing. As noted above, symptoms are the most important factor in determining whether cataract surgery is appropriate for a particular patient. It would be grossly unfair and improper to find Dr. Chase's surgery recommendation

unprofessional based on the opinion of another physician who was presented with entirely different patient complaints.

Most importantly, none of the second opinion doctors performed contrast sensitivity testing on any of the 11 complaining patients. Dr. Chase performed contrast sensitivity and glare testing on every patient. Each of the 11 patients demonstrated enormous contrast sensitivity losses as compared to age-adjusted norms: All scored 85% to 90% below the average for their age, and 40% to 80% below the bottom 2.5% of all patients in their age groups. (PF ¶¶ 275, 333, 378, 406, 425, 443, 484, 509, 538, 567, 594.) The undisputed evidence shows that CST is a “more comprehensive” measure of visual function than the Snellen testing performed by the State’s ophthalmologists. It also demonstrates that reduced contrast sensitivity constitutes a significant real-life visual deficit that can be remedied by cataract surgery.

The State has known since the outset of this case that CST and BAT were central to Dr. Chase’s decisionmaking and would be central to his defense. Nonetheless, it chose to rely on second opinion physicians who do not perform, and know little about, CST. It also chose not to have the complaining patients’ contrast sensitivity tested by an ophthalmologist who could corroborate or disprove the results of Dr. Chase’s testing. It did not even present (because it could not) any witnesses who could call into question Dr. Chase’s methods of administering CST and BAT. As a result, all of evidence available to the Board demonstrates that the 11 complaining patients had significant real-life contrast sensitivity deficits that were caused by their cataracts and would be remedied through cataract surgery. This alone is sufficient grounds on which to reject the State’s claim that Dr. Chase acted unprofessionally in offering cataract surgery to them.

Of course, the State could have begun to remedy the deficiencies in their experts’ opinions by having them review the complaints the patients made to Dr. Chase, along with the

CST/BAT results achieved by the patients in Dr. Chase’s office and render opinions based on that information. However, with one notable exception,² the State did not even ask its ophthalmologist witnesses to review Dr. Chase’s charts with respect to the complaining patients, much less render an opinion on the propriety Dr. Chase’s care based on the information available to him. Only Dr. Chase’s expert witness, Dr. James Freeman, was asked to examine all of the doctors’ charts for each of the 11 patients. Taking account of all of the information gleaned by all of the testifying ophthalmologists, Dr. Freeman concluded that Dr. Chase’s surgical recommendations as to all 11 patients met the standard of care set forth in the AAO PPP. (PF ¶¶ 266-617.) Simply put, the only ophthalmologist to review all of the evidence concluded that Dr. Chase acted professionally. This Board must do the same.

I. It Is Proper To Offer Cataract Surgery To Patients With Relatively Early Cataracts And Good Snellen Visual Acuity If They Have Other Cataract-Related Complaints That Cannot Be Treated With Glasses.

Lacking any specific evidence that Dr. Chase acted unprofessionally in offering his patients cataract surgery, the State falls back on the faulty principles that caused it to summarily suspend Dr. Chase’s medical license over three years ago, arguing that surgery was unjustified because the 11 complaining patients had early cataracts, good Snellen scores, and visual complaints that “just weren’t that bad.” The State’s position remains mistaken and against the overwhelming weight of the evidence.

As discussed in detail above, it has been proven beyond a shadow of a doubt that relatively early cataracts—even cataracts designated “trace”—often cause significant visual symptoms, and it is impossible to determine the visual significance of a cataract thought its physical appearance. (PF ¶ 162.) Snellen visual acuity is ill-suited to detect and quantify most

² The State had originally asked Dr. Morhun to review an incomplete faxed copy of Dr. Chase’s chart for Helena Nordstrom. However, it did not ask him to testify based on that chart at the trial for obvious reason: Dr. Morhun was never provided with Dr. Chase’s entire chart and was badly mistaken in his reading of the portion of the chart that he did receive.

of the visual symptoms caused by cataracts, particularly early cataracts. (PF ¶¶ 51, 59, 61.) Contrast sensitivity testing is a more comprehensive measure of visual function and cataract-related visual symptoms. (PF ¶ 59.) Finally, it is the patient, not the physician, who must decide whether her symptoms are bad enough to justify surgery. (PF ¶ 95.) The patient can only make that decision once the physician has offered cataract surgery, along with all of the information the patient needs to assess the severity of her symptoms in light of the potential risks and likely benefits of surgery. (PF ¶ 96.) Neither the State, its testifying ophthalmologists, nor this Board can decide that a patient's visual symptoms were insufficiently severe to justify an offer of cataract surgery. The undisputed evidence shows that Dr. Chase provided that choice to the only people who could make it: his patients.

The testimony of Dr. Chase's own patient witnesses—Dr. Betty Morewood, Maureen Heath, Lynda Douglass, Lydia Chobot, Marcella Fulmer, and Gloria Gil—confirms the propriety of Dr. Chase's decision to offer surgery to the complaining witnesses. (PF ¶ 52.) Like many of the complaining witnesses, most of Dr. Chase's own patient witnesses had relatively early cataracts that were not yet significantly affecting their Snellen visual acuities. However, those patients nonetheless had significant real-life visual disabilities that were corroborated by Dr. Chase's CST with BAT testing. (PF ¶ 52.) Dr. Chase offered each of them cataract surgery, and each decided in favor of surgery after weighing the risks and benefits. One of those patients, Dr. Betty Morewood, first declined surgery out of fear of the associated risks, but ultimately sought out surgery when her visual symptoms continued to worsen despite excellent Snellen vision. Robert Vautier and Maureen Heath were offered surgery even though they were unable to pay for it. These patients testified that cataract surgery resolved their visual symptoms and allowed them to comfortably resume their normal daily activities. (PF ¶ 52.) Although there was often no or little improvement in their Snellen visual acuities, their real-life functional vision, and

therefore their quality of life, was vastly improved through cataract surgery. If Dr. Chase acted properly in offering these patients the choice of cataract surgery—and there can be no doubt that he did—he also acted properly in offering it to the similarly situated complaining patients.

J. The State Has Not Proven By A Preponderance Of The Evidence That Ms. Nordstrom Did Not Have Cataracts.

The State alleges that, alone among the 11 complaining patients, Ms. Nordstrom had no cataracts. The State's evidence on this point does not meet its burden of proving its allegations by a preponderance.

Ms. Nordstrom came to Dr. Chase complaining of blurry distance vision for approximately three weeks and difficulty seeing clearly to drive at night, among other things. (PF ¶¶ 267, 269-72.) When she viewed the Snellen chart in Dr. Chase's office, she performed poorly, both as measured by the autorefractor, the technician, and by Dr. Chase himself. (PF ¶ 271.) Even Ms. Nordstrom testified that when her vision was tested prior to dilation, the Snellen chart was blurry. (PF ¶ 272.) The measurements taken by Dr. Chase's technicians showed that there had been no change in her glasses prescription that would account for her symptoms. (PF ¶ 273.)

Dr. Chase's January 2003 examination revealed that Ms. Nordstrom was suffering from cataracts, which were causing her vision problems. (PF ¶ 274.) Despite performing an exhaustive examination, including an Amsler grid test—yet another test performed by none of the other testifying physicians with respect to any of the complaining patients—he found no other condition that might account for her symptoms. (PF ¶ 276.) Dr. Freeman, who examined the charts maintained by both Dr. Chase and Dr. Morhun, agreed that there was no cause other than cataracts for Ms. Nordstrom's visual symptoms. (PF ¶ 277.)

However, prior to performing cataract surgery on Ms. Nordstrom, Dr. Chase ordered her to get 2-hour blood sugar and CBC test. (PF ¶ 280.) Her surgery was contingent upon the results. (PF ¶¶ 280-81.) Dr. Chase testified that he did this in order to determine if her cataracts were caused by fluctuating blood sugar levels, which can cause transitory cataracts that disappear as sugar levels stabilize. (PF ¶ 281.) As always, he was concerned with his patients' entire health, not just their eyes.

The State's ophthalmologists agree that fluctuating blood sugar levels can cause transitory cataracts, sometimes referred to as water clefts. (PF ¶ 284.) Dr. Morhun acknowledged that the only reason an ophthalmologist might order a patient to have a blood sugar test is concern that a patient's glucose intolerance is affecting her vision and to detect incipient diabetes, further bolstering Dr. Chase's explanation. (PF ¶ 282.) Ms Nordstrom declined to get the blood sugar test Dr. Chase had ordered and did not go forward with surgery. (PF ¶ 290.) She testified that her distance vision nonetheless improved over the coming months—a fact that she attributed to new glasses.

Dr. Morhun found no cataract when he examined Ms. Nordstrom five months later in June 2003. (PF ¶ 299.) By that time, her Snellen vision had greatly improved. Dr. Morhun confirmed, however, that her vision did not improve due to new glasses. (PF ¶ 300.) Her prescription had not changed. Indeed, based on his examination, Dr. Morhun could not find any reason for Ms. Nordstrom's radically improved vision. (PF ¶ 301.) Although the State bears the burden of proof, it has offered no explanation for Ms. Nordstrom's case.³ This failure alone requires the Board to rule in favor of Dr. Chase on the State's allegation that she had no cataracts.

³ Although Dr. Morhun speculated that Ms. Nordstrom's fluctuating vision could have a number of theoretical causes, he admitted that neither his examination nor Dr. Chase's examination offers support for those theories. Ms. Nordstrom has refused to be re-examined by Dr. Chase or his experts.

However, the totality of the evidence suggests two highly plausible explanations, both consistent with Dr. Chase's innocence. First, as discussed above, there is a strong possibility that Ms. Nordstrom did, in fact, have fluctuating blood sugar levels that caused transitory cataracts that interfered with her vision. Those cataracts had disappeared by the time Dr. Morhun examined her five months later. This explanation is strongly corroborated by the fact that Ms. Nordstrom's vision appears to have returned to normal without any change in her glasses prescription.

Second, there is a strong possibility that Dr. Morhun simply failed to see Ms. Nordstrom's early cataracts, which were intermittently interfering with her vision. This explanation is consistent with Dr. Morhun's failure to see several other cataracts diagnosed by the State's other ophthalmologist witnesses: Dr. Tabin diagnosed Ms. McGowan as having a nuclear cataract, but Dr. Morhun failed to see it, Dr. Irwin diagnosed Ms. McGowan as having a cortical cataract, but Dr. Morhun failed to see it, Dr. Irwin diagnosed Ms. Salatino as having a cortical cataract, but Dr. Morhun failed to see it. (PF ¶ 309.) Unsurprisingly, every ophthalmologist who was asked, either by the State or the Respondent, testified under oath that good, honest ophthalmologists sometimes fail to notice cataracts that other doctors see. (PF ¶ 172.)

Dr. Morhun's failure to see Ms. Nordstrom's cataracts is also consistent with the lack of care Dr. Morhun exercised when reviewing Dr. Chase's charts for the Board's investigator, when he overlooked that Dr. Chase had refracted Ms. Nordstrom, overlooked that her glasses had not changed, and overlooked that he had been provided with incomplete records that were obviously missing the bottom one-quarter of each page. (PF ¶ 310.) Dr. Morhun's failure to notice cataracts in Ms. Nordstrom's eyes is particularly unsurprising when viewed in light of the

undisputed fact that Ms. Nordstrom falsified her symptoms to him, specifically disclaiming that she had ever experienced vision problems in the past. (PF ¶¶ 293-94.)

Dr. Morhun's continued insistence that he did not fail to notice Ms. Nordstrom's cataracts is unfortunately consistent with his unwillingness to admit to the prior important mistakes he made in assessing Dr. Chase's treatment of Ms. Nordstrom. Dr. Morhun learned in August 2004 that his July 2003 expert report, upon which Dr. Chase's summary suspension was based, was mistaken in a number of important respects. (PF ¶ 312.) He was absolutely mistaken regarding his central conclusions that Dr. Chase never refracted Ms. Nordstrom (the record demonstrates she was refracted no fewer than three times) and that she would have benefited tremendously from a simple glasses change (he now admits there was virtually no change in her glasses prescription and that this fact was plainly evident in the chart). (PF ¶ 312.) Dr. Morhun went so far as to say that had he been given complete information, he would not have rendered the same opinion regarding Dr. Chase. (PF ¶ 312.) Nonetheless, Dr. Morhun failed to bring his mistakes to the attention of the Board, or urge the State to do so, even though he believed that Dr. Chase did not receive a "fair shake" in the summary suspension proceeding. (PF ¶ 312.) It was only through the Respondent's cross-examination of Dr. Morhun, undertaken over the strong objection of the State, that these crucial mistakes were made known to the Board.

Given the serious omissions and deficiencies attending Dr. Morhun's testimony, and the lack of any explanation of Ms. Nordstrom's symptoms by Dr. Morhun, the Board must find that the State has failed to prove by a preponderance of the evidence that Ms. Nordstrom had no cataracts when examined by Dr. Chase.

K. The State Has Not Demonstrated That Dr. Chase Falsified His Patients' Charts To Support His Surgery Recommendations.

The Amended Superseding Specification of Charges next alleges that Dr. Chase falsified his patients' charts in order to support his surgery recommendations. Again, it is important to note that the State does not simply contend that Dr. Chase kept his charts in an improper or confusing manner. Instead, it alleges that he willfully and affirmatively falsified his charts in a number of different ways in order to make it appear that his patients needed cataract surgery when in fact they did not.

1. Dr. Chase Did Not Falsify His Patients' Vision Test Scores.

In its Specification of Charges, the State alleges that Dr. Chase purposefully "falsified" his patients' vision test scores because those scores were "improperly based on the results of the CST with BAT" and "not on the Snellen Test." (*See, e.g.*, Amended Superseding Specification of Charges ¶¶ 50, 96, 291, 323.) The State also contends that Dr. Chase "improperly measured [his patients'] visual acuity by using the CST with BAT." (*Id.* ¶ 207.) However, the State has not introduced a shred of evidence that Dr. Chase's charted vision scores were "false" or "falsified" because they were based on CST and BAT. Nor has it presented an iota of proof that it is "improper" to measure a patients' vision through use of CST and BAT in addition to Snellen testing. To the contrary, the evidence points to the opposite conclusion.

According to the State's own witnesses and the American Academy of Ophthalmology, CST and BAT are legitimate parts of a cataract evaluation. (PF ¶¶ 59-76.) Glare and contrast sensitivity testing often reveal significant real-life, cataract-related visual deficits that are not detected by Snellen testing. (PF ¶¶ 59-76.) In this sense, these tests provide a more accurate and proper assessment of patients' functional vision, not a "false" or "improper" assessment. If the

State's evidence demonstrates anything, it is that simply performing Snellen testing on cataract patients may provide an incomplete assessment of how they see in real life.

The State has not attempted to call into question Dr. Chase's methods of testing CST and BAT. Nor could it. Dr. Chase's decision to use the VectorVision sine wave CST in conjunction with the BAT on its highest setting conforms to VectorVision's expectations of how the test should be used, is in conformance with the way that other doctors around the country test contrast sensitivity and glare, and even conforms to the FDA's own guidelines. (PF ¶¶ 72, 123.) According to Dr. Ginsburg, who pioneered the use of CST in the clinical setting and conducted an experiment to test the scientific validity of Dr. Chase's testing methods, Dr. Chase's use of CST and BAT for assessing his cataract patients' functional visual deficits was proper and "conservative." (PF ¶¶ 141, 244.)

Similarly, Dr. Chase's decision to occasionally re-test his patients' CST and BAT vision after he had examined them, and therefore after their eyes had been dilated for the purpose of facilitating his physical exam, was consistent with sound medicine and science. (PF ¶ 72.) In the absence of a visually significant cataract, dilation will not materially affect the CST/BAT scores of most patients just as it will not affect their best corrected Snellen visual acuity. (PF ¶¶ 74-75, 55-56.) A patient with a visually significant cataract may experience a rise or fall in her CST/BAT score after dilation, depending on the type and location of the cataract. (PF ¶ 74.) The tests results of the complaining patients who were retested using CST and BAT after dilation confirm that retesting patients after dilation will not necessarily decrease their tests scores: Jan Kerr took two CST/BATs on November 20, 2002, and there was virtually no difference between her pre- and post-dilation test scores. (PF ¶ 75.) Whether a patient's vision changes or not, a physician may gain valuable diagnostic information by re-performing CST and BAT after dilation. For instance, testing CST with BAT after dilation best approximates real life situations

when the pupil is wide when exposed to glare, such as night driving.⁴ Finally, the BAT manual itself specifically endorses reperforming BAT after dilation. (PF ¶ 72.)

Moreover, the State has not alleged or proven that Dr. Chase's CST with BAT scores were rendered "false" or "improper" simply by virtue of their position in the chart. The undisputed evidence shows that every ophthalmologist has a unique way of keeping his or her charts. (PF ¶ 147.) And each physician who has testified placed his or her vision scores at a unique location within those charts. (PF ¶ 149.) Most doctors were hard pressed to interpret other physicians' charts. (PF ¶ 151.) The State's evidence shows that ophthalmologists should organize their charts, and their vision scores, in a way that allows them to provide their patients with the highest quality ophthalmic care. (PF ¶ 149.)

There is no evidence that Dr. Chase did anything other than that: His undisputed testimony is that he placed his patients CST with BAT scores next to the section designated "V" on the front page of his examination notes when he concluded that those scores best reflected his patients' real life functional vision. (PF ¶ 144.) He also recorded each patient's best corrected Snellen visual acuity on the vision test slip and placed that slip prominently at the very front of the patient's chart, along with any Snellen vision obtained through use of the autorefractor. (PF ¶ 143.) When other physicians needed to review his charts, he sent them a summary sheet clearly labeling his CST with BAT scores as such. (PF ¶ 153.) When asked, he even told insurance companies exactly how he was charting vision. (PF ¶ 154.) Importantly, the insurance companies did not ask him to change anything about his charting methods. (PF ¶ 154.)

⁴ When a driver confronts oncoming headlights at night, those headlights will not cause the driver's pupil's to shrink; instead, the pupils will remain wide because the overall light levels reaching the retina are not great enough to cause constriction of the pupil. In fact, Dr. Evans, who performed a study designed to test this proposition, confirmed that even halogen headlights do not cause pupils to shrink in night driving circumstances.

Just one look at the charts of the State’s ophthalmologist witnesses confirms that Dr. Chase’s method of charting his patients’ vision was not unprofessional in any way. Unlike Dr. Chase, the State’s physician witnesses generally measured only their patients’ Snellen visual acuity; they did not have multiple vision scores for each visit like Dr. Chase. Yet the ophthalmologists still did not chart even that single piece of information in a consistent manner. (PF ¶¶ 146-48.) Some, like Dr. Tabin, placed their patients’ incoming Snellen vision, not their best corrected Snellen vision, next to the section labeled “V” in their charts. (PF ¶ 148.) Others said that they expected a patient’s best corrected Snellen vision to appear in that place on a chart. Still others, like Dr. Guilfooy, did not record their patients’ vision in any legible way anywhere in their charts. (PF ¶ 151.) Finally, some doctors do not even measure each patient’s best corrected visual acuity, much less record it in their charts, even when they are recommending cataract surgery. (PF ¶ 152.) By comparison, Dr. Chase measured his patients best corrected Snellen vision three different times, along with their best corrected CST and BAT vision, and recorded both scores in his chart in a consistent and easy-to-understand manner. The State has introduced no evidence that these scores are false, or that Dr. Chase’s charting practices were misleading or improper.

2. Dr. Chase Did Not Falsely Describe His Patients’ Cataracts When He Labeled Them “Dense.”

The Specification of Charges next contends that Dr. Chase affirmatively falsified some of his patients’ charts when he described their cataracts as “dense.” As the sole basis for this allegation, the State relies on the fact that other ophthalmologists described the same cataracts as “early” cataracts, “trace cataracts,” or cataracts rated “1” or “2” on a scale of 1 to 4. It has ignored, and asked the Board to discredit, Dr. Chase’s consistent explanation that he used the word “dense” to denote cataracts that were functionally visually significant, rather than to

describe their physical attributes. For good reason: The State's own witnesses have said there is nothing wrong with this practice. (PF ¶ 159.)

There is no requirement that ophthalmologists rate their cataracts at all. Nor is there is a single rating system that all doctors must follow. (PF ¶ 163.) Every doctor who testified applied his or her own rating system differently. The State's own ophthalmologists also freely admitted that all rating scales used to describe cataracts are highly "subjective," "nebulous," and "imprecise." (PF ¶ 164.) For this reason, a physician is free to use the rating system that best helps him provide quality care to his patients. (PF ¶ 159.)

Examination of the State's physicians' charts reveals just how subjectively and differently all doctors describe cataracts. When two of the State's doctors examined the same patient, they *almost never* agreed in their physical description or grade of the patient's cataracts. (PF ¶¶ 170-77.) In some instances, the same doctors even described the same cataracts differently on two separate visits. (PF ¶ 176.) The State's single retained expert, Dr. Morhun, failed to identify both nuclear and cortical cataracts noted by other doctors on visits preceding and following his own. (PF ¶ 173.) Dr. Cleary failed to identify nuclear, cortical, and posterior subcapsular cataracts diagnosed in Frank Cole by Dr. Maguire, a retinal specialist. (PF ¶ 174.) Dr. Tabin repeatedly failed to note cortical cataracts that he had personally identified in a patient on prior visits. (PF ¶ 176.)

The only thing that the Board can conclude from the State's evidence is that all clinicians' identifications and descriptions of cataracts are highly subjective and display wide inter-observer and intra-observer variations. That subjectivity applies not only to the grade assigned to a cataract; it extends to whether a cataract exists or not. When asked when he considers a "trace opacity" to be a cataract, Dr. Irwin replied: "It depends on the day." (PF ¶ 179.) In light of this, it is nonsensical to label one physician's grading system as "false" simply

because it is different—even vastly different—from another’s. To do so would be to conclude that every one of the State’s own physician witnesses was falsifying his or her charts as well.

Perhaps understanding that it cannot prove the falsification alleged in the Specification, the State has attempted to argue (but has not formally alleged) that Dr. Chase was wrong to combine a functional descriptor such as “dense” with his physical description of the type and location of the cataract. However, the State has not introduced any evidence that combining functional and physical descriptors is even marginally improper, much less unprofessional conduct warranting license suspension. In fact, many the State’s own physicians admit that they do the same thing, adjusting the grade or description they assign to a cataract in order to take account of how that cataract is affecting the patient’s vision. (PF ¶¶ 180-82.) Dr. Cavin testified that, like Dr. Chase, he uses the descriptor “dense” in part to “describe to [him]self what [he] expect[s] its impact on vision to be.” (PF ¶ 181.) Dr. Irwin, too, admits to using a “functional definition” when describing cataracts, accounting for how the cataract affects vision. (PF ¶ 182.) Dr. Cleary invented her own category of cataract, called “haze,” to give herself more information on how her patients’ cataracts were affecting their vision. (PF ¶ 167.) All of these physicians recorded their functional descriptions in the physical examination portions of their charts. (PF ¶ 180.) If, as the evidence shows, many other good physicians similarly combine functional and physical descriptors in order to best treat their patients, and record those descriptors in the physical examination portion of their charts, the Board cannot reasonably conclude that Dr. Chase acted unprofessionally in doing so.

Finally, the State has failed to show that anyone would be confused or misled by Dr. Chase’s use of the “dense” descriptor. (PF ¶ 184.) The State’s own witnesses convincingly demonstrate that there exist no rules, whether promulgated by insurance companies, regulatory authorities, or professional organizations, that require cataracts to reach a certain grade before

surgery is proper. There is no evidence that insurance companies would view these descriptions at all. Every doctor to address the issue has testified that he or she would never rely on another doctor's description of a cataract to guide his or her surgical decision—in part because such descriptors are so subjective. (PF ¶ 183.) Many doctors use unique cataract descriptors, and many are counterintuitive: Dr. Cavin uses the phrase “quite clear” to designate a lens that has early opacity. (PF ¶ 168.) While that description, viewed in isolation, might well lead another ophthalmologist to conclude that the lens was in fact clear, it is perfectly appropriate for Dr. Cavin to use the grading system that allows him to provide his patients the highest quality care. Dr. Chase was entitled to do the same.

3. Dr. Chase Did Not Falsify His Patients' Symptoms.

As to four patients—Susan Lang, Marylen Grigas, Joseph Touchette, and Jan Kerr—the State alleges that Dr. Chase falsified some of the visual symptoms recorded in their charts. Upon cross-examination, however, all of these patients admitted that they complained of the very problems Dr. Chase summarized in their charts—and often noted the same symptoms in their own handwriting on patient questionnaires. Although the State has suggested that a doctor and his staff have an obligation to record verbatim the patients' complaints of symptoms, rather than summarizing or paraphrasing them, the State's evidence has proven something entirely different: According to the State's own doctor witnesses, it is perfectly acceptable and professional for an ophthalmologist and his technicians to paraphrase patients' complaints and to record their own understanding of the patients symptoms based on everything revealed by the patient, her vision testing, and the eye doctor's physical exam. (PF ¶ 45.) In fact, the physician has the obligation to do just that. (PF ¶ 46.) If a doctor or technician intends to record the patient's complaint verbatim, he or she uses quotations to indicate that fact. (PF ¶ 187.) Otherwise, it is reasonable, indeed expected, for a doctor to paraphrase.

Moreover, because patients often do not recognize or admit to cataract-related visual symptoms, the physician's testing will sometimes reveal visual deficits that the patient does not or will not acknowledge. (PF ¶ 40.) In those instances, the doctor has the right and the obligation to record his own conclusions regarding the patient's visual deficits, even if the patient disagrees with the ophthalmologist's assessment. (PF ¶ 47.) As long as the physician's conclusions regarding the patient's symptoms are supported by the information revealed during the entirety of the examination, those conclusions cannot be deemed "false." (PF ¶ 48.)

Through its questioning at the hearing, the State suggested that Dr. Chase acted improperly by recording his conclusions regarding his patients' symptoms—such as "can't see to drive safely at night"—in the "history" section of the patients' charts, even though the patients may not have reported those symptoms at the time the technicians were taking their initial history. The State's own evidence shows that most physicians engage in precisely the same practice, recording their patients' visual symptoms in the history section of the chart regardless of whether those symptoms were revealed at the beginning, middle, or end of the examination. Dr. Chase's expert witnesses agreed. (PF ¶ 47.) There is nothing wrong, or misleading, about this practice.

The entirety of the evidence available to the Board shows that Dr. Chase accurately recorded his patients' visual symptoms in their charts, and that his conclusions regarding their symptoms were amply supported by all of the information revealed during the course of his examination.

a. Dr. Chase Accurately Recorded Susan Lang's Symptoms.

The State first charges that Dr. Chase falsified Susan Lang's symptoms when he wrote that she could not see to drive safely. (Superceding Specification ¶¶ 91-92.) Dr. Chase's conclusion is entirely consistent with Ms. Lang's own description of her symptoms, both at the

time she saw Dr. Chase and at the hearing. In filling out her own history sheet, Ms. Lang complained of being bothered by “glare” and “halos.” (PF ¶ 376.) At the hearing, she admitted that she had been experiencing those symptoms when driving at night and that Dr. Chase voiced concern about her ability to drive safely. (PF ¶ 363.) Her CST and BAT scores confirmed that Ms. Lang had a severe contrast sensitivity deficit when tested under glare conditions designed to simulate night driving. Specifically, Ms. Lang scored at patch 3 or below on the 6 c/d column of the VectorVision contrast sensitivity test face. (PF ¶ 378.) Dr. Ginsburg, who sits on the vision testing standard-writing committee for the FDA, performed an experiment in order to determine the functional significance of the complaining patients’ test scores. Based on that experiment, he concluded that, using Dr. Chase’s testing methods, a CST with BAT score of patch 3 or below is indicative of a night driving deficit that the FDA itself would designate as a safety hazard. (PF ¶ 242.) As a result, even without Ms. Lang’s substantial complaints regarding night driving, her CST with BAT scores alone support Dr. Chase’s conclusion that she could not see to drive safely.

While Ms. Lang may not believe that her vision had fallen to the point that she was unsafe to drive, it was more than reasonable for Dr. Chase to conclude, and tell her, that it had. Moreover, Ms. Lang subsequently confirmed that her vision was no longer meeting her needs when she chose to undergo elective cataract surgery after receiving an extensive informed consent presentation, both oral and written, by Dr. Chase and his nurse. She agreed that, after surgery, her glare symptoms were “eliminated.” (PF ¶ 389.) On the basis of the State’s own evidence, the Board cannot find that Dr. Chase falsified Ms. Lang’s symptoms.

b. Dr. Chase Accurately Recorded Marylen Grigas’ Symptoms.

The State next contends that Dr. Chase falsified Ms. Grigas’ chart when he wrote that she could not see to drive safely due to glare from her cataracts. (Superceding Specification ¶ 144.)

However, on the day of her exam, Ms. Grigas filled out a questionnaire in which she stated that she was choosing to have cataract surgery because she was “bothered by glare,” was having “trouble seeing in poor or dim light” and “driving at night,” and was “concerned about driving.” (PF ¶ 410.) During her sworn testimony, Ms. Grigas admitted that she had been experiencing increased discomfort when driving at night. (PF ¶ 406.) It would defy common sense and the weight of the evidence to rule in the State’s favor in light of these admissions. Indeed, if the State had bothered to interview Ms. Grigas before prosecuting her claims, it could not have brought this allegation in good faith.

Moreover, Ms. Grigas’ CST with BAT scores fell at patch 2 and patch 3. As explained above, these scores are indicative of night driving deficiencies that the FDA would designate a safety hazard. (PF ¶ 242.) They also precisely correlate with Ms. Grigas self-described symptoms. For all of these reasons, Dr. Chase’s description of her symptoms was far from false; it was supported by all of the information revealed by his examination.

c. Dr. Chase Accurately Recorded Mr. Touchette’s Symptoms.

The State does not take issue with the fact that Joseph Touchette had blurry vision when he visited Dr. Chase in 1998. However, in paragraph 321 of the Specification, the State charges Dr. Chase with falsifying Mr. Touchette’s chart when he wrote that Mr. Touchette’s blurry vision “interfered with his life.” Mr. Touchette readily admitted that he was experiencing increasing problems reading his computer screen due to deteriorating near and intermediate vision. (PF ¶ 535.) He testified that he used the computer nearly every day for work. (PF ¶ 532.) He told Dr. Chase’s staff that he “had to work to see things clearly.” (PF ¶ 535.) The technician placed this complaint in quotation marks to indicate that it was a verbatim account of Mr. Touchette’s symptoms. (PF ¶ 535.) His contrast sensitivity, measured with his best possible correction, also showed a significant deficit, falling to patch 2 and 3. (PF ¶ 538.)

The AAO PPP states that blurry vision more than once or twice a month “has a significant impact on functional status and well-being, particularly on problems with work or other daily activities.” (PF ¶ 11.) Dr. Chase was therefore well within the bounds of professionalism in concluding and recording that Mr. Touchette’s near-daily blurred view of the computer screen interfered with his life. The fact that Mr. Touchette ultimately decided that the interference was not sufficient to warrant surgery does not render Dr. Chase’s comments unreasonable or false.

d. Dr. Chase Accurately Recorded Ms. Kerr’s Symptoms.

Finally, the State contends that Dr. Chase falsified Ms. Kerr’s symptoms when he wrote in her chart that she “can’t see to drive safely” at night. (Superceding Specification ¶ 380.) Once again, Dr. Chase’s rendition of the patient’s symptoms is entirely consistent with all of the evidence presented by the State. First, Ms. Kerr admitted in her testimony that she told Dr. Chase’s technician that she was having difficulty seeing to drive at night, as recorded by the tech in her chart. (PF ¶ 591.) She also testified that she was bothered by glare. In filling out her Eye Health History form, she stated that she was experiencing “decreased vision.” (PF ¶ 591.) Her CST with BAT results, which reflected her best corrected contrast sensitivity and glare vision, confirmed that she was experiencing significant problems in glare conditions, plummeting to patch 2 and 1. (PF ¶ 594.) Even Dr. Irwin’s subsequent examination of Ms. Kerr revealed that her high contrast Snellen vision dropped to 20/60 in her right eye when exposed to the BAT on its medium setting. (PF ¶ 603.) At the hearing, Ms. Kerr also admitted that she had been the at-fault driver in a serious automobile accident that was caused by her inability to see a stoplight when the sun shone on her windshield—a classic glare problem. (PF ¶ 592.) In short, Dr. Chase’s description of Ms. Kerr’s symptoms was entirely consistent with her own description to his technician, her real life experience, Dr. Chase’s test results, and the test results of Dr. Irwin.

4. Dr. Chase Did Not Falsify His Charts When He Recorded That His Patients Wanted Their Cataracts Removed.

The Amended Superceding Specification of Charges alleges that Dr. Chase falsified his charts when he wrote that four patients—Jane Corning, Joseph Touchette, William Augood, and Jan Kerr—wanted their cataracts removed. All four patients ultimately decided against having surgery. The State does not contend that Dr. Chase mistakenly, or even negligently, misinterpreted his patients' wishes. Rather, it alleges that he wrote that his patients wanted cataract surgery when he *knew* they did not. The State's evidence supports no such allegation.

Dr. Chase testified that after he delivered his initial informed consent presentation to patients with visually significant cataracts, he asked the patients to visit his nurse in order to complete the informed consent process, submit to preoperative measurements, and schedule cataract surgery. (PF ¶ 201.) If the patient indicated that they did not want to visit the nurse, Dr. Chase would have his staff schedule a follow-up exam in one or two years. (PF ¶ 192.) If the patient indicated that he or she would go to see the nurse, Dr. Chase noted in the chart that the patient wanted his or her cataracts removed, accurately reflecting his understanding of his patients' desires at that time. (PF ¶¶ 450, 598.) He would then send them out of his examination lane and to the nurse's office to complete the informed consent process and schedule surgery. The nurse would then record whether the patient finally scheduled surgery, or not. (PF ¶¶ 453, 599.)

Jane Corning and Jan Kerr went to see the nurse and opted to postpone surgery after receiving the entire informed consent presentation. According to their own testimony, neither patient told Dr. Chase that she did not want cataract surgery; instead, each went to the nurse's office as he suggested, leaving him with to conclude that they were, in fact, scheduling surgery. (PF ¶¶ 450, 598.) For both Ms. Corning and Ms. Kerr, the nurse accurately recorded in the chart

that the patient had decided to postpone a decision regarding surgery. (PF ¶¶ 453, 599.) As a result, when viewed as a whole as they must be, the patients' charts accurately reflect their wishes.

Joseph Touchette and William Augood opted not to go see the nurse, and instead left Dr. Chase's examination lane and exited the office, never to return. Neither patient informed Dr. Chase that he was not going to see the nurse, as instructed. (PF ¶¶ 546, 573.) As Mr. Touchette put it: "As far as he knew, I was going to see the scheduling nurse." (PF ¶ 546.) Dr. Chase should not and cannot be penalized because his patients quietly decided against surgery without telling him or his nurses.

More importantly, for these patients too, the charts viewed as a whole accurately reflect that the patients decided against surgery. There are no additional entries suggesting that the patient completed the informed consent process, undertook preoperative testing, or scheduled surgery. Mr. Touchette's chart accurately notes "patient decided against surgery." (PF ¶ 547.) In short, for each of the four patients, Dr. Chase's charts accurately reflect Dr. Chase's understanding of his patients' desires and accurately record that the patients ultimately decided against surgery. Only the State, with its myopic view of a single sentence in each patient's chart, could conclude that Dr. Chase purposefully falsified his charts in this respect. Consistent with its obligation to weigh all of the evidence, this Board cannot reach the same conclusion.

5. Dr. Chase's Did Not Falsify His Charts When His Technicians Wrote That A "Second Opinion" Was Given To His Patients.

Finally, the State argues that Dr. Chase falsified his charts when his scribes placed the notation "second opinion given" as part of their recording of Dr. Chase's informed consent presentation. The Superseding Specification of Charges contends that this entry indicates that Dr. Chase's patients "received a second opinion from another physician as to [his patients'] need

for cataract surgery.” (Superceding Specification ¶¶ 292, 324, 386.) The State’s charge is as unsupported as it is nonsensical.

As an initial matter, the State has introduced absolutely no evidence that Dr. Chase wrote, or asked his scribes to write, “second opinion given” in his charts. As Dr. Chase has explained, his technicians invented this shorthand phrase to record the fact that he had given a portion of his standard informed consent presentation. (PF ¶ 197.) Dr. Chase then went on to explain that presentation repeatedly and at length, and it is nothing as sinister as the State has alleged: Dr. Chase told each patient to whom he was recommending cataract surgery that “if she went to any other medical eye doctor . . . and said she came for a second opinion because Dr. Chase said she needed cataract surgery, she would be told [that] if she saw well enough to suit her, its not going to damage her eyes *not* to have the surgery.” (PF ¶ 194.) As Dr. Chase explained, his hypothetical “second opinion” was one of several ways in which he and his office staff explained to patients that: (1) cataract surgery was elective, not necessary, and they should only have it if their vision no longer suited their needs; and (2) a cataract was not a life threatening condition, such as a tumor, that needed to be fixed immediately. (PF ¶ 195.) While Dr. Chase never instructed his scribes to write down that the patient was given a second opinion, he never objected to their chosen shorthand notation because he believed it adequately captured what he was telling his patients: Any good doctor will likely tell a patient that cataract surgery is elective and depends on her own visual needs. (PF ¶ 197.) Notably, the State has called none of Dr. Chase’s former scribes or technicians to refute his rendition, despite ample opportunity to do so. For good reason: They would confirm Dr. Chase’s truthful account.

The State seems to suggest that others might be misled by his technician’s shorthand notation to believe that the patients received a true second opinion, either by Dr. Chase or from another doctor while being examined by Dr. Chase. The State’s interpretation of this notation is

nonsensical in the extreme. No doctor can provide his patients with his own second opinion during the course of his examination. There is no way another doctor can render a second opinion regarding a patient during the course of the first doctor's exam. There exists no patient, physician, or insurer who could reasonably conclude otherwise.

The State is exploiting the unique "second opinion" notation to invent confusion wrongdoing where none exists. The Board should reject the State's position and construe Dr. Chase's charts consistent with the presumption of innocence to which he is entitled, rather than with the presumption of guilt that the State improperly seeks to impose on these proceedings.

L. Dr. Chase Did Not Discourage His Patients From Receiving A Second Opinion.

With respect to four patients—Ms. Nordstrom, Ms. Lang, Ms. Kerr, and Mr. Augood—the State alleges that Dr. Chase intentionally discouraged them from seeking a second opinion regarding cataract surgery. Dr. Chase testified, and the patients' charts reflect, that he gave each of them the same presentation regarding second opinions. As described in detail above, he informed patients that other ophthalmologists would tell them that they did *not* need cataract surgery if their vision suited their needs. He repeated this presentation, verbatim, over and over again during the merits hearing. (PF ¶ 194.) Even three-and-a-half years after his practice was closed, he could recite the presentation identically again and again because he had given it thousands of times in the preceding decade.

Thousands of patients received Dr. Chase's informed consent presentation regarding a hypothetical second opinion and properly understood its intended message: Any good ophthalmologist will tell you that cataract surgery is elective and is appropriate only where your vision no longer meets your needs. However, it appears from the testimony of Ms Lang, Ms. Nordstrom, Ms. Kerr, and Mr. Augood that a handful of patients misunderstood Dr. Chase to be

discouraging them from receiving a second opinion. The evidence shows that this was never Dr. Chase's intent and, just as importantly, that no patient was actually discouraged from getting a second opinion by what Dr. Chase told them.

While Dr. Chase's method of delivering his informed consent procedure was different, it was not unique. Other physicians, testifying for both the State and the Respondent, confirmed that they give similar presentations to their patients in order to emphasize the elective nature of cataract surgery. Dr. Cavin tells patients that a second opinion doctor may well agree with his assessment, but if the doctor does not agree, both he and the patient might learn something. (PF ¶ 199.) Dr. Javitt used a similar presentation with his glaucoma patients, telling them that if they seek a second opinion, other physicians in the area may not choose to treat their condition surgically, but that he felt surgery was the best treatment. (PF ¶ 200.) Dr. Watson agreed that any good ophthalmologist, upon discerning a cataract, will tell the patient that if her vision is good enough to suit her, she doesn't need cataract surgery. That is all Dr. Chase was attempting to do.

The State's allegation also ignores that, prior to receiving surgery, each patient was also required to attend an hour-long informed consent interview with Dr. Chase's nurse. If patients asked about getting a second opinion, the nurse would tell them: "Second opinions are your privilege. They're your prerogative. And they are sound medicine. . . . We're all professionals here and there's no personal--there's nothing personal about this. If you want a second opinion, you should have one." (PF ¶ 214.) The nurse's presentation is manifestly inconsistent with the State's theory that Dr. Chase was actively discouraging his patients from seeking a second opinion.

If Dr. Chase was, in fact, attempting to discourage his patients from seeking a second opinion, his presentation was singularly ineffective. Of the four patients who alleged that Dr.

Chase discouraged them from seeking a second opinion, three quickly sought and received examinations by not one but two other eye doctors, thereby getting second and third opinions. Ms. Nordstrom saw both her optometrist and Dr. Morhun. (PF ¶ 291.) Ms. Kerr was examined by Dr. Irwin and Dr. Guilfoy. (PF ¶¶ 602, 611.) Mr. Augood was examined by Dr. Sudarsky and Dr. Cavin. (PF ¶¶ 575, 577.)

Only Ms. Lang decided against seeking a second opinion. However, Ms. Lang, herself a medical researcher familiar with informed consents, testified that she understood that cataract surgery was elective, that is was only indicated if she felt she could not function adequately due to poor sight produced by a cataract, and that she should not have the procedure unless she was seeing poorly enough that she wanted to go forward with surgery. (PF ¶¶ 384-86.) She chose surgery nonetheless. In light of all of the evidence presented the parties, the Board must conclude that Dr. Chase neither intended to discourage his patients from receiving a second opinion nor actually discouraged them from doing so.

M. The State's Remaining Allegations Of Unprofessional Conduct Are Unsupported By The Evidence.

In addition to the allegations discussed above, the State has brought a handful of charges of unprofessional conduct that are unique to individual patients. Those charges, too, are unsupported by the evidence.

1. Dr. Chase Acted Professionally In Recommending Glaucoma Surgery To Frank Cole.

The State alleges that Dr. Chase acted unprofessionally in recommending combined cataract and glaucoma surgery to Frank Cole because Dr. Cleary later concluded that Mr. Cole did not have glaucoma. (Superceding Specification of Charges ¶ 264.) The evidence convincingly demonstrates that Mr. Cole not only had glaucoma, but that Dr. Cleary's failure to properly examine, diagnose, and treat Mr. Cole has contributed to his permanent loss of vision.

Primary open angle glaucoma (“glaucoma”) is a progressive, chronic optic neuropathy in adults where intraocular pressure (“IOP”) and other currently unknown factors contribute to damage which, in the absence of other identifiable causes, there is a characteristic acquired atrophy of the optic nerve. (PF ¶ 464.) If left untreated, glaucoma leads to progressive and irreversible blindness, beginning with visual field loss at the periphery or in the center of the visual field. (PF ¶ 465.) As a result, early intervention is particularly important in treating glaucoma. Doctors should always err on the side of treatment, because the consequence of non-treatment is permanent vision loss. (PF ¶ 466.)

A comprehensive glaucoma evaluation should include, among other things, measurement of IOP, a magnified stereoscopic evaluation of the optic nerve through a dilated pupil, imaging of the optic nerve through stereoscopic photographs or computer-based means, automated visual fields, and periodic gonioscopy. (PF ¶ 469.) The single most important indicator of glaucoma is the appearance of the optic nerve, which can only be assessed through a dilated pupil. (PF ¶ 469.) Thus, in evaluating a glaucoma patient, the ophthalmologist should document an inability or decision not to dilate, including the reasons therefore. (PF ¶ 470.)

Dr. Chase gave Mr. Cole comprehensive glaucoma care. On every visit he performed a dilated examination of the back of Mr. Cole’s eye, including the optic nerve. On every visit, he compared the appearance of Mr. Cole’s optic nerve to the stereoscopic photos he had taken. On every visit he performed automated visual fields testing. On every visit, he measured Mr. Cole’s IOP. He also performed periodic gonioscopy, examining Mr. Cole’s trabecular meshwork. (PF ¶¶ 477-78.) The results of these examinations demonstrated the Mr. Cole’s optic nerve was atrophying, that he was losing peripheral vision, and that glaucoma eye drops were not controlling Mr. Cole’s condition. (PF ¶ 479.) Dr. Chase was therefore justified in offering him glaucoma surgery.

Mr. Cole declined surgery and was examined by Dr. Cleary. Despite the fact that he had previously been diagnosed with and treated for glaucoma, Dr. Cleary: (1) performed only one more dilated examination of Mr. Cole in the following 13 years, (2) never performed gonioscopy on Mr. Cole; (3) never took optic nerve photographs of Mr. Cole; (4) never documented that she had compared Mr. Cole's optic nerves to the photos taken earlier by Dr. Chase, despite the fact that she had obtained those photographs; and (5) only sporadically performed automated visual fields tests on Mr. Cole. (PF ¶¶ 487-89.) Dr. Cleary never recorded any reason not to dilate Mr. Cole. (PF ¶ 490.) Although Dr. Cleary performed almost none of the components of a comprehensive glaucoma evaluation, she stopped treating Mr. Cole with glaucoma eye drops and declared him free of the disease.

Sadly, the records of Dr. Cleary and Dr. Maguire, a retinal specialist who examined Mr. Cole on one occasion, convincingly demonstrate that Mr. Cole's optic nerve has continued to atrophy and that he has lost significant peripheral and central vision since leaving Dr. Chase's care. (PF ¶ 494.) Dr. Freeman confirmed these facts upon examining all of the eye records for Mr. Cole. (PF ¶ 494.) Far from demonstrating that Dr. Chase acted unprofessionally, the evidence shows that, through his extraordinarily comprehensive evaluation of Mr. Cole, Dr. Chase was the only physician who properly diagnosed and treated him.

2. Dr. Chase Did Not Offer Dr. Olson Cataract Surgery.

The State charges that Dr. Chase acted unprofessionally in failing to note in his chart that he recommended cataract surgery to Dr. Olson. (Superceding Specification of Charges ¶ 180.) In fact, Dr. Chase did not offer or recommend cataract surgery to Dr. Olson, and Dr. Olson does not contend otherwise. Dr. Chase diagnosed Dr. Olson, a retired dentist, as having cataracts. (PF ¶ 426.) As noted above, he had significant visual complaints, low vision test scores, and no cause for his symptoms other than his cataracts. (PF ¶¶ 424-26.) Nonetheless, Dr. Chase did not

offer Dr. Olson surgery during their single visit. The only specific comment Dr. Olson remembers Dr. Chase making about his vision is that if he were a long haul truck driver, his vision would preclude him from working. (PF ¶ 427.) He has no specific recollection of Dr. Chase telling him that if he wanted to correct his vision he needed surgery. (PF ¶ 427.) Dr. Chase did not advise him about the risks or benefits of surgery and definitely did not pressure him to have surgery. (PF ¶ 427.) As a result, Dr. Chase's medical records for Dr. Olson, unlike the records of each of the other 10 complaining patients, properly does not mention any discussion regarding cataract surgery. (PF ¶ 428.)

3. Dr. Chase Did Not Schedule Ms. Grigas For Surgery One Day After He Diagnosed Her.

Dr. Chase's medical records indicate that Ms. Grigas was examined and offered surgery on September 9, 2002 and that she scheduled her surgery for her first eye on October 1, 2002, and later cancelled. Ms. Grigas believes that she was scheduled for surgery on September 10, 2002, the day after surgery was recommended. The State charges Dr. Chase with unprofessional conduct because his records do not conform to her recollection. (Superceding Specification of Charges ¶¶ 149-50.)

After Dr. Chase offered Ms. Grigas surgery, she recalls him saying that he had an opening on his surgical schedule the next day. (PF ¶ 408.) When Ms. Grigas met with the nurse, Susan Grohn, she found her to be very professional and helpful. She viewed Ms. Grohn as a patient advocate. (PF ¶ 411.) Ms. Grigas recalls asking Ms. Grohn if she could attend a rehearsal the day after surgery, and Ms. Grohn said most people prefer to sleep. (PF ¶ 411.) She told the nurse that she did not want to have the surgery the next day, and Ms. Grohn told her that she should not do anything unless she wanted to do it. Ms. Grohn then informed Dr. Chase that

Ms. Grigas did not want to have the surgery the next day, and Ms. Grigas remembers Dr. Chase saying it would be “no problem.” (PF ¶ 411.)

Ms. Grigas mistakenly recalls that she then left the office after being scheduled for surgery the next day and that she called and cancelled the surgery when she got home. That recollection is directly and substantially contradicted by Dr. Chase’s medical records and the records produced by Ms. Grigas (both of which were written by Susan Grohn). (PF ¶ 412.) Dr. Chase’s medical record had an entry made by Susan Grohn between 10:30 and 11:30 a.m. on September 9, 2002, indicating that she had completed advising Ms. Grigas of the information involved in the pre-op teaching and the informed consent and that Ms. Grigas had a good basic understanding of the information. (PF ¶ 413.) It also indicated that Ms. Grigas gave permission for Ms. Grohn to notify Ms. Grigas’ primary care physician of the scheduled surgery and that Ms. Grigas said she had an appointment with her doctor later that week and would discuss it with her. (PF ¶ 413.) Cataract surgery on Ms. Grigas’ left eye was scheduled for 6:30 a.m. on October 1, 2002, and Ms. Grigas was instructed to begin her pre-operative drops on September 28, 2002. (PF ¶ 413.) Nurse Grohn made another entry on September 16, 2002, stating that she had notified Dr. Sandoval of Ms. Grigas’ October 1st left eye surgery. (PF ¶ 413.) On September 17, Ms. Grohn made another entry on Ms. Grigas’ record stating that Ms. Grigas had called and cancelled the cataract surgery, saying she might schedule at a later date. (PF ¶ 413.)

Marilyn Grigas produced documents to the State and federal government that had been given to her at Dr. Chase’s Office, and they too contradicted her recollection that she had been scheduled for surgery on September 9th. (PF ¶ 414.) She had a single appointment card provided by Susan Grohn showing that she was scheduled for surgery on October 1 at 6:30 a.m. (PF ¶ 414.) Ms. Grigas produced a prescription for preoperative eye drops given to her by Dr. Chase on September 9th with instructions signed by both Ms. Grigas and Susan Grohn, directing

her to begin the drops in her left eye on September 28th and continue until her surgery on October 1st. (PF ¶ 414.) When Marilyn Grigas was asked how she could square her recollection that she had been scheduled for surgery on September 10th when both her records and Dr. Chase's records showed that surgery was set for October 1st, she twice responded by saying it was a "mystery." (PF ¶ 415.)

Ms. Grigas expressed certainty about other material facts that were unequivocally contradicted by the medical records. On her direct examination she testified that her spectacles were meeting her needs and she had worn the same glasses for about ten years without any change. When asked if she got new spectacles in 2001 when her prescription changed, she replied several times that she "did not." When asked if she was sure of that, Ms. Grigas replied "Quite." In fact, the records show that she received and was charged for new glasses on August 22, 2001 and on July 15, 1999. (PF ¶ 416.)

Simply put, the record reflects that Ms. Grigas expressed a certitude regarding her recollection of the details of the examination that was not justified by her actual ability to recall those details. (PF ¶ 417.) Dr. Chase does not question Ms. Grigas' honesty, but her recollection regarding the operative events is far too unreliable a basis on which to base a finding of unprofessional conduct by Dr. Chase.

4. Jane Corning Was Not Scheduled For Cataract Surgery On Independence Day.

Dr. Chase offered Jane Corning cataract surgery on Friday, June 30, 2000. Ms. Corning's recollection is that Dr. Chase suggested that she could be scheduled for surgery the following Tuesday, which was July 4, 2000. Dr. Chase's records do not reflect that Ms. Corning was scheduled for surgery on that date. The State again charges Dr. Chase with falsifying his records because they do not conform to his patient's recollection of a particular date nearly seven

years ago. The documentary evidence shows, however, that Dr. Chase's office was closed on July 4 and no surgery was scheduled for that day. (PF ¶ 448.) Moreover, at the hearing, Ms Corning conceded that she might have been mistaken in thinking Dr. Chase meant Tuesday, July 4th, rather than July 11th or 18th. (PF ¶ 448.) The evidence also makes plain that there is nothing wrong with scheduling cataract surgery four days after it is recommended. (PF ¶ 458.) In the end, the evidence simply does not support the State's contentions.

N. The Complaining Witnesses Have Serious Credibility Deficits.

The errors in Ms. Corning's and Ms. Grigas' recollections serve as reminders of the serious credibility problems that attend much of the complaining patients' testimony. As an initial matter, only one of the eleven complaining patients filed her complaint prior to Dr. Chase's highly publicized summary suspension. The publicity surrounding that suspension announced to all of Dr. Chase's former cataract patients that their eye doctor was a liar and a cheat and that he had purposefully performed surgery that he knew his patients did not need. Viewing their past experience with Dr. Chase through the distorted lens of fraud created by the summary suspension proceeding, it is no wonder that many of them concluded that they had been treated badly by Dr. Chase. Indeed, given the extraordinarily widespread and negative publicity, and the many thousands of patients who were offered or received cataract surgery from Dr. Chase, it is notable that the State could do no better than the 10 additional complaining patients, all of whom admittedly had cataracts, vision complaints, and very low vision scores. The Board must consider all of these patients' testimony in light of the fact that they never raised any concerns about Dr. Chase's professionalism prior to being told that he was a fraud.

Three of the eleven patients—Ms. Salatino, Ms. Lang, and Ms. McGowan—have yet another reason to be biased against Dr. Chase: They are participating in lawsuits against Dr. Chase and his wife Brianne Chase, seeking money damages for their allegedly unnecessary

cataract surgery, among other things. (PF ¶ 345, 358, 520.) These patients' monetary incentives led them to provide literally unbelievable explanations for why they complained of serious vision problems when filling out their own symptom questionnaires.

Many of the patients, like Mr. Cole who was last treated by Dr. Chase in 1992, understandably do not remember the details of their treatment by Dr. Chase because it occurred many years ago and because they had no reason to even attempt to recall it until July 2003, when they read about the summary suspension. (PF ¶¶ 471-75.) Mr. Augood admitted numerous times during his testimony that his memory of relevant events was not good. (PF ¶ 582.) Unfortunately, it is these unmemorable details that form the basis of much of the State's case.

Many patients testified inconsistently with their prior sworn trial and deposition testimony. For instance, Ms. Nordstrom contradicted herself again and again on such basic issues as what her symptoms were, initially claiming that she sought eye drops for a pet rabbit, then claiming that they were for her mother, and finally claiming that she had dry eyes, even though she had expressly denied that symptom under oath on prior occasions. (PF ¶ 321.) Mr. Augood also attempted to disclaim much of his prior sworn testimony from Dr. Chase's federal trial, claiming that he had been unable to testify accurately because of the stress of the situation. (PF ¶ 583.) If these witnesses were unable to testify accurately under oath in a federal court, they cannot be relied upon here to do so.

Mr. Augood and Ms. Nordstrom, demonstrated serious, if unexplained, biases against Dr. Chase during their hearing testimony. After repeatedly refusing to answer questions from counsel, Ms. Nordstrom began yelling at Dr. Chase regarding his previously undisclosed (and still unconfirmed) treatment of her mother. (PF ¶ 317.) Mr. Augood was easily distracted during his testimony at the merits hearing, complaining that Dr. Chase's counsel was "fidgeting" and thereby preventing him from testifying. (PF ¶ 584.)

The testimony of these patients forms the core of the State's case against Dr. Chase. However well-meaning most of the complaining witnesses, their testimony is not a sufficiently reliable basis on which to end the career and permanently destroy the reputation of a physician who served his patients well for 37 years.

O. Dr. Chase Has Always Been The Most Innovative And Forward-Thinking Ophthalmologist In Vermont.

In weighing all of the State's allegations, the Board must also keep in mind that Dr. Chase has always been the most innovative and forward-thinking ophthalmologist in Vermont. He has often chosen to practice differently than his peers, but time and again his practices have been proven through time to be the best for his patients, even if they were decidedly unprofitable for him. The same is true of his decisions to use CST and BAT on every cataract patient and to provide his patients the choice to treat their relatively early but visually significant cataracts through surgery.

Dr. Chase was the first doctor in Vermont to perform cataract surgery through the modern method known as phacoemulsification, adopting that procedure in the early 1970s, after learning it from its inventor at a hospital in New York City. (PF ¶ 619.) It was then a controversial procedure; it is now the method by which virtually all modern cataract surgery is performed. Dr. Chase was the first doctor in Vermont to implant intraocular lenses ("IOLs"); although nearly all cataract surgery is now performed using IOLs, their use was highly controversial when Dr. Chase first utilized them. (PF ¶ 620.) Dr. Chase purchased the first excimer eye laser in Vermont. (PF ¶ 621.) He made it available to all area ophthalmologists. (PF ¶ 621.) Dr. Chase was the first and only ophthalmologist in Vermont to perform his surgeries in an ambulatory surgical center ("ASC"), spending at least \$500,000 to fit it up and operating it without reimbursement from insurance companies for the first 10 years. (PF ¶ 622.) The vast

majority of eye surgery, including cataract surgery, is performed in an ASC setting, because it is safer and more comfortable for the patients. (PF ¶ 622.)

Although Dr. Chase performed his cataract surgeries in his own ASC, he employed rigorous quality assurance standards and voluntarily invited scrutiny of his practice by others. Dr. Chase chose to have his ASC certified by AAAHC, an independent reviewer of surgical centers. (PF ¶ 625.) Dr. Chase also voluntarily applied to be certified in cataract surgery by the American College of Eye Surgeons; in order to gain certification, Dr. Chase's cataract surgical practices were reviewed in-person and on videotape by national experts, who also reviewed 50 consecutive cataract surgery charts. (PF ¶ 626.) Dr. Chase was the only ACES-certified ophthalmologist in Vermont. (PF ¶ 626.) Dr. Chase also set up a Quality Assurance committee, comprised of himself, his office staff, and an outside physician. (PF ¶ 627.) Dr. Chase invited the medical director of CHP, then the State's largest insurer, to sit on his Quality Assurance committee. (PF ¶ 627.) No other physician who testified before the Board employed such rigorous quality assurance practices.

In structuring his clinical practice, Dr. Chase routinely placed his patients' well-being ahead of his own profit. Dr. Chase's office performed expensive and time-consuming automated visual fields on every patient as part of a routine exam, even though he could not and did not charge insurers or patients for most of those tests; he felt that routine visual fields were the best way to detect early glaucomatous vision change. (PF ¶ 634.) Dr. Chase's office performed expensive and time consuming pre-operative tests on every surgical patient; although the tests were not reimbursed by insurance, Dr. Chase felt it was important for determining the health of the patient's cornea prior to cataract surgery. (PF ¶ 635.) Dr. Chase's office employed a registered nurse to administer his complete informed consent procedure, rather than a less expensive, non-medical employee. (PF ¶ 636.) Dr. Chase's office had a formal policy,

memorialized in writing, stating that: “If a patient needs to come in for emergency or follow-up but indicates that he/she can’t afford the bill, encourage them to come in anyway. *We do not want to deny a patient services because they can’t afford it.*” (PF ¶ 637 (emphasis added).)

The State asks the Board to ignore all of these facts, and to focus instead only on the 11 complaining patients devoid of important context. The State’s motivation is as transparent as it is improper. An ophthalmologist who offers his patients the most modern and comprehensive eye care available in Vermont, without regard for personal profit, is not a physician who would purposefully perform surgery that he knew his patients did not need. Moreover, a physician who has consistently practiced differently from his peers, only to be proven correct, should not be deemed unprofessional for once again adopting the most modern approach to cataract surgery.

P. The State’s Investigation And Prosecution Of This Case Have Violated Its Duties To The Board, To The Profession, And To Dr. Chase.

Finally, in evaluating the credibility of the State’s case, the Board must take account of the manner in which the State investigated and prosecuted it. The State has brought career-ending charges of unprofessional conduct against Dr. Chase and has the burden of proving them. In doing so, it owes the Board and Dr. Chase a duty of candor. Its primary obligation is not to win this case, but to make certain that the truth is served. The State and Board’s investigator have violated that obligation at every turn. Those violations cast doubt upon the legitimacy of the State’s entire case and, if left unpunished, threaten the legitimacy of this Board’s regulatory power over the profession.

At the outset of this case, the State and the Board’s investigator concluded that Dr. Chase was a rogue physician, dedicated to performing cataract surgery on his patients regardless of whether they would benefit from it. Their firmly held conclusions were based on an expert report that was fundamentally mistaken. They were based on an affidavit that was purposefully

falsified. They were based on the mistaken notion that early cataracts do not cause significant symptoms and that patients with good Snellen vision should not be given the option of cataract surgery. They were based on the notion that CST and BAT is a fundamentally “false” measure of vision.

Since July 2003, the tenets of the State’s prosecution have fallen away one by one. Yet, the State has refused to re-evaluate its position and has worked assiduously to prevent the Board from hearing any evidence that might call into question its initial impression of Dr. Chase. Amy Landry’s affidavit was proven to be falsified, but the State did not withdraw it. Instead, it simply decided not to call her as a witness, fearing its duplicity would be further exposed. Dr. Morhun’s expert report was proven to be mistaken in several important respects, but the State did not bring that crucial fact to the Board’s attention, instead objecting as the Respondent did so. The State learned that, far from being “false,” CST and BAT represent “more comprehensive measures” of visual function than the Snellen visual acuity upon which its experts relied. But instead of evaluating the complaining patients’ CST and BAT vision itself, or attempting to challenge the validity of Dr. Chase’s testing methods, it attempted to keep Dr. Chase’s expert witnesses, Drs. Ginsburg and Evans, from offering any testimony on the subject. When the Beaver Dam study demonstrated that early cataracts can cause significant visual symptoms justifying surgery, the State simply ignored it, declined to show it to its own expert witnesses, and objected to its admission at the hearing as “irrelevant.”

While the foundation of its case was crumbling, the State exploited the publicity surrounding Dr. Chase’s summary suspension to recruit complaining witnesses who had never before voiced concerns about Dr. Chase’s care. Although it seems almost unimaginable, neither the State nor the Board’s investigator bothered to even interview the complaining witnesses regarding their claims before publicly airing them against Dr. Chase. When Dr. Chase then

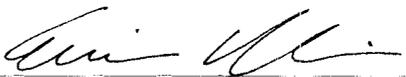
attempted to interview the complaining patients himself, the State and the Board's investigator illegally and unethically urged the patients, in writing, not to speak with the Respondent or his attorneys. And when Dr. Chase sought to have them examined by an independent expert, the State objected at every turn.

Although the State bears the burden of proof in this case, only Dr. Chase has consistently sought to provide the Board with all of the information needed to decide it, confident that the Board will exonerate him as long as it is allowed access to all of the relevant evidence, both favorable and unfavorable. He even took the unprecedented step of paying for and assembling a system for the electronic presentation of evidence at the merits hearing, and then freely allowed the State to use that system to prosecute him, further demonstrating confidence that the facts will prove the propriety of his actions.

In short, the manner in which the State has investigated and prosecuted this case should shake the Board's confidence that the allegations of unprofessional conduct are the product of a searching examination of the evidence, rather than the blind pursuit of victory or the stubborn refusal to admit a tragic mistake. It should reject the State's charges, strongly express its disapproval of the tactics utilized by the State and the Board's investigator, and enter judgment in favor of Dr. Chase on all counts.

Dated at Burlington, Vermont, this 7th day of March, 2007.

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