

**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 REBUTTAL BRIEF

Respondent David S. Chase, M.D., hereby submits the following Post-Trial Rebuttal Brief and the accompanying Supplemental 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 his Proposed Findings and Supplemental Proposed Findings.

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I. INTRODUCTION.

The State's own Post-Trial Memorandum and Proposed Findings convincingly demonstrate that the State has not and cannot meet its burden of proving by a preponderance of the evidence that Dr. Chase engaged in the specific unprofessional conduct alleged in the Amended Superseding Specification of Charges. Rather than attempting to support its allegations that Dr. Chase purposefully recommended surgery that he knew his patients did not need and purposefully falsified his medical charts, the State attempts to prove something else entirely: that Dr. Chase failed to engage in a "collaborative process" of assessing his patients' functional vision, "pressured" his patients into surgery, "removed" his patients from their health care decisions, and created records that other unidentified persons might find "misleading." While advancing these arguments, the State indulges the very pattern and practice allegations that it said it had withdrawn from this litigation. It also contends that Dr. Chase acted out of an improper motive, even though it said throughout the trial that his motive was not relevant.

There are at least two fatal problems with the arguments the State now advances: They are not included in the Amended Superseding Specification of Charges and are not supported by the record evidence. The Board must forcefully reject the State's tactics and its proposed findings as inconsistent with the evidence and with the State's obligation to advance only those allegations of unprofessional conduct that have been formally leveled against Dr. Chase, rather than attempting to invent new charges that it believes better fit the evidence presented.

II. DISCUSSION.

The State's Proposed Findings and Memorandum attempt to expand the charges against Dr. Chase and misrepresent the record evidence in countless ways. Many of the State's misstatements have already been addressed in the Respondent's Post-Trial Brief and Proposed Findings. Others are so baseless as to warrant no response. Nonetheless, some of the State's

most egregious efforts to change its charges against Dr. Chase, as well as some of its most serious misrepresentations, are addressed below.

A. The State Has Not Charged, And Cannot Argue Or Prove, That Dr. Chase Engaged In A Pattern And Practice Of Unprofessional Conduct.

Prior to the commencement of the hearing in this case, the State formally dropped its charges that Dr. Chase engaged in a “pattern and practice” of unprofessional conduct.¹ It dismissed these charges in a successful attempt to persuade the Board to preclude Dr. Chase from introducing extensive and critical exculpatory evidence. The excluded evidence included Respondent’s summary charts analyzing key characteristics of Dr. Chase’s cataract and cataract surgery patients during specified periods, testimony from other patients, and testimony from Brianne Chase and certain employees regarding his practices in evaluating cataracts and offering cataract surgery.

Despite dropping those charges and excluding Dr. Chase’s evidence, the State begins its Memorandum in Support of Its Proposed Findings of Fact (“State’s Memorandum”) by relying upon the very pattern and practice argument that it expressly promised it would not make. It contends in the very first sentence of its first argument that “the testimony of the eleven patients in this case described essentially the same experiences with Respondent” and then goes on to emphasize alleged similarities in the treatment of these patients. (State’s Memorandum at 2-4.) Although the substance of this pattern and practice argument is fundamentally wrong, the argument is clearly an effort by the State to buttress the testimonial claims of one patient by arguing that the remaining ten State patient witnesses had the same experience, are making the same claim, and that the truth of the complaints is evinced by their number and similarity. This is a classic attempt to prove that an act occurred by introducing alleged evidence that it was part

¹ On March 16, 2006, it filed an Amended Superseding Specification of Charges purporting to delete the pattern and practice allegations. (See State of Vermont’s Proposed Findings and Conclusion of Law at 1.)

of a recurring pattern and practice, also known as similar act evidence. *See* V.R.E. 404. Moreover, and more seriously, it represents an egregious example of the State using misrepresentation to deprive an accused of his right to rebut the State's allegations of wrongdoing by the presentation of contrary evidence.

Even if the eleven patient witnesses' contentions were accurate and similar, which they are not, they would represent only the isolated perspectives of a few handpicked witnesses that the State culled from a truly huge number of patients treated by Dr. Chase during the eleven year period embraced by this case. The State's three surgical patients and eight nonsurgical patients were selected from patients Dr. Chase saw between 1992 and 2003. During that period he performed 250 to 300 cataract surgeries annually (2,500 to 3,000 total), treated an even greater number of cataract patients non-surgically, and had approximately 80,000 patient encounters. It seems self evident that if Dr. Chase's patterns and practices are to be examined, they should be examined against a broader and more objectively selected sampling of patients than the eleven complaining witnesses selected by the State. Instead, the State has culled 11 patients from the tens of thousands treated by Dr. Chase, using their written complaints as the primary selection criteria, in an attempt to construct an artificial reality in which only the testimony of the 11 handpicked state witnesses is considered, and only after that testimony has been filtered through the State's distorted view of proper ophthalmology practices. It then implicitly argues that the allegations of the 11 patients must be true because of their similarity.

The State has repeatedly, and successfully, argued to the hearing panel that the facts relating to any of the other thousands of cataract patients Dr. Chase treated during the same period should be ignored. Now it expressly states that the Board "has heard the public speak in the persons and voices of eleven people who were patients," (State's Memorandum at 1), ignoring that through its efforts the voices of far more patients were silenced. It is a position that

would be laughable if it was not being made in such a serious matter, and if it had not already been successful in excluding critically important evidence that Respondent sought to introduce at the hearing. The Board must either reject the State's pattern and practice argument or allow Dr. Chase to present all of his countervailing evidence.

B. After Repeatedly Arguing That Motive Is Irrelevant, The State Argues That Dr. Chase Had An Improper Motive In Maintaining His Charts As He Did.

The State also repeatedly claims that Dr. Chase falsified patient records out of a motive to justify cataract surgery that was not medically indicated, (State's Memorandum at 4, 6), and urges the Board to make numerous findings regarding that motive. (*See, e.g.*, State's Proposed Findings ¶¶ 22, 23, 27, 39.) The State's arguments and proposed findings with respect to Dr. Chase's alleged motive contravene the representation it made both before and during the hearing. Specifically, in seeking to exclude Respondent's proffered evidence, the State represented that it was not required and was not seeking to prove motive or that Dr. Chase purposely or otherwise engaged in fraud. It stated that whether Dr. Chase's motives were altruistic or nefarious was beside the point. (*See, e.g.*, State's Reply Memorandum in Support of Motion In Limine, at 4-6 (June 27, 2006).) Having made those representations to the Hearing Panel to successfully preclude the Respondent's presentation of evidence, it now requests the Board to adopt findings that the evil motive underlying the supposed false record entries was the justification of unnecessary cataract surgery.

Motive is the purpose that incites a person to commit a particular action.² Having alleged that the Respondent intentionally falsified patient medical records, the State attempts to prove the allegation by supplying his motive or reason for so acting, claiming that his purpose was to justify cataract surgery that he knew was not medically indicated. Put another way, the State is

² Webster's New International Dictionary (2d Ed. 1949).

contending that the Board should believe the records were knowingly falsified by Respondent because, it alleges, he had a strong reason or motive to do so, i.e. justify unnecessary surgery. In doing so the State breaches the very representations it made to this Hearing Panel to successfully circumscribe the Respondent's evidence.

The State neglects to explain to whom the Respondent was supposedly attempting to justify the surgery, but its implicit contention is manifest: governmental and private insurance companies were supposedly misled by Dr. Chase's charting practices.³ The State, however, does not make that allegation directly because: 1) Dr. Chase was exonerated of that very charge in the federal trial; 2) the State cannot prove that any of the entries at issue were material to insurance reimbursement decisions; 3) Exhibits 522 and 523 contain Dr. Chase's accurate responses to the only inquiry about his records ever made by an insurer; 4) the entries, as set forth below, are not false; and 5) if the State specified the object of the scheme to falsely justify the surgery, the State would have undermined its successful motion in limine to exclude Respondent's proffered evidence regarding motive.

The State, having repeatedly stated that motive was irrelevant, that it would not seek to prove it and Respondent should not be allowed to prove it, cannot be permitted to now advance a theory of motive and request the Board to make findings of fact based upon it. It is true that an allegation that a doctor intentionally falsified his patients' medical records makes little sense, and thus lacks probative force, without some proof explaining why the doctor engaged in conduct so patently inconsistent with his legal and ethical obligations. But that is exactly what the State chose to do in representing that the reason underlying the putatively intentional falsifications was

³ None of the eleven patients had ever seen their medical records and the testifying doctors uniformly testified that they would not base a surgery decision on the records of another doctor. Moreover, none had seen Dr. Chase's records before the suspension and most had not even reviewed the records before their testimony in this hearing. Moreover, it was Dr. Chase's practice to send second opinion doctors a summary of his medical records – summaries that contain no statements that the State has challenged as being false or inaccurate.

irrelevant, and they must in fairness be held to their representation. Otherwise, the Respondent should be permitted to introduce his proof relating to Dr. Chase's lack of a motive to falsely justify unnecessary cataract surgery. That proof included, among other things, testimony from Brianne Chase and additional patients and summary charts.

C. There Is No Charge, And No Evidence, That Dr. Chase Pressured A Single Patient Into Cataract Surgery.

In its Amended Superseding Specification of Charges, the State alleges that Dr. Chase engaged several different types of unprofessional conduct. It does not, however, charge that he coerced patients into having cataract surgery. Now that the evidence is closed, the State attempts to allege for the very first time that Dr. Chase "pressured" all 11 complaining patients into having cataract surgery that they did not want or need. (State's Memorandum at 1.) The Board must reject this argument, both because it is not contained in the State's charging document and because it is manifestly inconsistent with the evidence and the truth.

The State has an obligation to inform the Respondent of the nature of the charges he is facing so that he can present all of his countervailing evidence. It cannot ask this Board to enter judgment against him on allegations that it has never before raised. Yet, that is exactly what the State is asking the Board to do. Worse yet, the State successfully argued to exclude evidence, proffered by Ellen Flanagan, RN, and Brianne Chase, of the office practices designed to provide cataract patients with a pressure-free environment in which to make their surgical decisions. In light of the State's prior objections, the State's newfound argument that Dr. Chase was pressuring his patients into having surgery smacks of the gamesmanship that has typified the State's approach to trying this case. The Board must reject the State's arguments and its tactics.

The testimony and exhibits that have been allowed into evidence nonetheless convincingly demonstrate that Dr. Chase's practice never pressured any patient into having surgery he or she did not want.

1. The Surgical Patients Were Not Pressured.

Only three of the eleven complaining patients had cataract surgery, and there is not one whit of evidence that any of them was pressured into going forward with that surgery. To the contrary, each patient made a considered and pressure-free choice to have surgery after being informed of its potential risks and likely benefits.

a. Ms. Salatino Made Her Decision Only After Completing The Informed Consent Process And Considering The Quality Of Her Vision.

Without citation to any record evidence, the State asserts that Ms. Salatino was pressured into making her surgery decision before even meeting with the nurse, and that the informed consent process was a "mere formality." (State's Proposed Findings ¶ 43.) Ms. Salatino herself testified directly to the contrary.

Dr. Chase treated Ms. Salatino, her husband, and her children for over 35 years. (PF ¶ 326.) He diagnosed Ms. Salatino with cataracts in 1994, but informed her that the cataracts were not interfering with her vision and that the proper treatment was to monitor them to ensure that any effect on her vision would be detected. (PF ¶ 327.) Over the next six years, Ms. Salatino repeatedly complained of difficulty with glare and bright lights and had more trouble driving, particularly at night. Nonetheless, Dr. Chase recommended continued monitoring of her cataracts. On June 11, 2003, over nine years after Dr. Chase had first diagnosed Ms. Salatino with cataracts, he offered cataract surgery as the only effective means of ameliorating the visual deficiencies that she had been regularly complaining about during that period. (PF ¶ 335.) After speaking to Dr. Chase about the surgery, Ms. Salatino went to lunch and then came back to meet

with the nurse. (Respondent’s Supplemental Proposed Findings (“Supp PF”) ¶ 665.) She then completed the entire informed consent procedure with her husband present. The nurse clearly and thoroughly explained the risks of the surgery and the decision-making involved. She made it very clear that Ms. Salatino did not have to make a decision until the day of the surgery. (PF ¶ 337.) Ms. Salatino 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 her cataracts were 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 ¶ 338.)

Ms. Salatino then tentatively scheduled her surgery for July 15, 2003. During the five weeks between June 11 and July 15, 2003, Ms. Salatino carefully considered the issue of whether her vision was meeting her needs, and after thinking about it, consulting with her husband and reading the written material she had received, she decided to go forward with the cataract surgery. (PF ¶ 340.) She did not sign the informed consent form until the morning of her surgery.

In short, Ms. Salatino was given, and took advantage of, the opportunity and information to make a leisurely and considered decision regarding surgery, and decided only after meeting with the nurse and receiving the full informed consent presentation. The State’s argument that Ms. Salatino was forced to decide in favor of surgery before even meeting the nurse is entirely lacking in factual support. Indeed, it constitutes an affirmative misrepresentation to this Board.

b. Ms. Lang Was Not Pressured Into Surgery.

The State next contends that Dr. Chase pressured Ms. Lang, a trained medical professional, into undergoing cataract surgery when he showed her the results of her contrast sensitivity and glare testing. (State’s Proposed Findings ¶ 58.) However, when testifying under

oath, Ms. Lang agreed that there was nothing wrong with Dr. Chase showing her the results of her vision testing. In fact, she would have been upset if he had not shown her the results. (PF ¶ 374.) She went on to testify that the informed consent process administered by Dr. Chase's nurse was very thorough, even when compared to the informed consent processes she oversees in connection with human clinical trials. (PF ¶ 385.) After completing the informed consent process, Ms. Lang understood that she should choose cataract surgery only if she felt she could not function adequately due to poor sight produced by her cataracts. (PF ¶ 386.) She agreed that, at the time she chose to have surgery in 2003, no one placed any pressure on her. (PF ¶ 387.)

Ms. Lang, too, was a long-time patient of Dr. Chase. He began treating her in 1977. (PF ¶ 360.) He first diagnosed her as having cataracts in 1990. (PF ¶ 361.) From 1990 through 1999, Dr. Chase did not offer or recommend surgery to Ms. Lang because she was not reporting any symptoms attributable to her cataracts. (PF ¶ 362.) In 2000 and 2002, when Ms. Lang began complaining of glare caused by her cataracts, Dr. Chase spoke with her about the option of cataract surgery, but he did not pressure her in any way. (PF ¶¶ 367, 373.) By the time Ms. Lang chose to have surgery in 2003, she had been a patient of Dr. Chase's for over 25 years, had been diagnosed with cataracts for 13 years, and had briefly discussed cataract surgery with Dr. Chase on two prior occasions. The State's newfound allegation that Dr. Chase rushed her to surgery is simply a fiction.

c. Ms. McGowan Was Not Pressured Into Surgery.

The State alleges that Dr. Chase pressured Ms. McGowan into surgery by "consistently raising the issue of cataract surgery" with her during her visits. (State's Memorandum at 3.) Ms. McGowan herself testified that nothing could be further from the truth.

Ms. McGowan began receiving eye care from Dr. Chase in 1972. (PF ¶ 502.) Dr. Chase first diagnosed her with cataracts in 1997, and confirmed that diagnosis on each subsequent visit in 1999, 2001, and 2003. (PF ¶ 503.) According to Ms. McGowan, on each of these occasions, Dr. Chase discussed her cataracts with her and asked if she was experiencing any problems driving at night. Each time Ms. McGowan reported that she was seeing “starbursts” around oncoming headlights, (PF ¶ 504), and told Dr. Chase that the starbursts “bothered” her. (PF ¶ 505.)

On each visit, Dr. Chase explained to Ms. McGowan that surgery was one “option” that she could consider to remedy her symptoms. He did not pressure her in any way. In describing her understanding of the optional nature of the cataract surgery, Ms. McGowan stated: “It was my decision when I was ready. . . . When I couldn’t see the way I felt I should see it was time for me to have it done.” (PF ¶ 506.) In 1997, 1999, and 2001, Ms. McGowan told Dr. Chase that she was not yet ready for surgery, and Dr. Chase simply scheduled her for another appointment in two years, saying “When it bothers you enough, we’ll take care of it.” (PF ¶ 507.)

At the beginning of her examination in June 13, 2003, Ms. McGowan filled out an Eye Health History form, in which she indicated that she was “currently” being “bothered by glare.” On that same form, she indicated that she would “like more information about” “cataract surgery.” (PF ¶ 503.) At her June 13, 2003 examination, 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.)

Dr. Chase again offered Ms. McGowan cataract surgery in 2003. On this occasion, Ms. McGowan went through the entire informed consent process with Dr. Chase's nurse. She felt that it was thorough and, in fact, emphasized all of the risks associated with the surgery. (PF ¶ 513.) In 2003, Ms. McGowan still 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.) Ms. McGowan decided that her vision was bad enough for her to go through surgery. (PF ¶ 516.) She had cataract surgery on her right eye on July 1, 2003 and had scheduled surgery on her left eye for July 22, 2003, when her care was interrupted by the summary suspension. (PF ¶ 516.)

This history, confirmed by Ms. McGowan herself, reveals as nonsense the State's contention that Dr. Chase badgered Ms. McGowan into surgery by repeatedly raising the topic with her. Dr. Chase accurately diagnosed her with cataracts and, when she complained of symptoms from those cataracts, offered her the option of surgery. According to Ms. McGowan herself, that offer was not accompanied by any pressure. To the contrary, she correctly understood that she should choose surgery only when her vision "bothered her enough." That is exactly what Dr. Chase told her, and exactly what the AAO PPP requires.

2. Dr. Chase Did Not Pressure His Non-Surgical Patients Either.

Although the remaining eight patients chose not to have cataract surgery, the State nonetheless contends that Dr. Chase brought great pressure to bear on them in several ways during "what they believed to be a routine exam." (State's Memorandum at 2.) None of the practices that the State seeks to mischaracterize as pressure-packed was remotely improper, much less unprofessional.

a. The Non-Surgical Patients Saw Dr. Chase To Address Specific Vision Problems.

The State's pleadings suggest that the eight non-surgical patients simply came to Dr. Chase for routine checkups, with no visual problems, and were therefore shocked to learn that they had cataracts. The State implies that this shock constituted a form of pressure designed to force patients into surgery they did not want or need. The State's position makes no sense.

With a single exception, the parties agree that the complaining patients did, in fact, have cataracts when they were examined by Dr. Chase. Whether or not the complaining patients were surprised to learn of their condition, it was in no way unprofessional for Dr. Chase to tell them that they had cataracts and to propose a solution to their visual problems. To conclude otherwise would be to endorse the practice of withholding important health information and treatment from patients. Of course, some ophthalmologists, such as Dr. Watson, refuse to tell patients that they have early cataracts, so as to not upset them. (Supp PF ¶ 666.) Others, like Dr. Irwin, refuse to tell patients that their glare vision, as measured with the BAT, has fallen as low as 20/60. (PF at 609.) Dr. Chase practiced differently: He was committed to telling his patients all of the information they needed to make good decisions regarding their own ocular health.

Moreover, the State's invented notion that the complaining patients came to Dr. Chase for routine examinations, unaware of their cataracts or visual problems, is directly contradicted by the patients themselves. Some of the non-surgical patients had been diagnosed with cataracts by Dr. Chase years before. For instance, Marylen Grigas was diagnosed with cataracts in 1997, five years before Dr. Chase offered her surgery in 2002. (PF ¶ 401.) Prior to her 2002 examination, she had noticed that her vision had declined in dim light and that night driving had become more difficult. (PF ¶ 407.) Importantly, even before being examined by Dr. Chase, she correctly suspected that her cataracts were the cause of her vision problems. (PF ¶ 407.) As

pointed out in Dr. Chase's Post-Trial Brief, all of the patients came to Dr. Chase with specific complaints regarding their vision.

Finally, although it should go without saying, it is very often a routine exam that reveals a disease, even visually significant cataracts, that the patient did not previously recognize or appreciate. That is exactly why patients have routine exams. For instance, when Dr. Olson was examined by Dr. Guilfoxy and Dr. Cavin as part of "routine examinations," he felt that his vision was sufficient to meet all of his needs, including driving. In fact, due to his cataracts, his Snellen vision had dropped below the legal driving limit and as low as 20/60. (PF ¶¶ 434-36.) If an ophthalmologist diagnoses a patient as having visually significant cataracts, he has an obligation to inform the patient, whether the patient wants to hear it or not.

b. Dr. Chase Did Not Act Unprofessionally In Making Surgery Available As Soon As The Patients Wanted.

On a related note, the State contends that Dr. Chase pressured his patients into surgery by making it available quickly, sometimes within days or weeks. However, the State's own physician witnesses confirmed that there is no reason to wait to perform cataract surgery once the patient has decided to have the operation. (Supp PF ¶ 664.) Some patients, such as Ms. Lang, were comfortable moving forward with surgery quickly after the recommendation was made. Others, such as Ms. Grigas and Ms. Corning, required more time to consider the surgical decision. The evidence shows that Dr. Chase often gave his patients the option of proceeding to surgery within days or weeks of the recommendation, but always respected their wishes to have more time to consider their options.

c. It Was Proper For Dr. Chase To Accurately Tell His Patients That He Was ACES Certified.

As it did during the hearing, the State makes much of the fact that Dr. Chase accurately informed some of his patients of his accreditation by the American College of Eye Surgeons

(“ACES”). The State does not dispute that Dr. Chase was, in fact, the only ophthalmologist in Vermont with that certification. It does not even dispute the importance of the certification, which is bestowed upon ophthalmologists only after a rigorous review of their surgical skills and outcomes. Instead, it alleges that Dr. Chase pressured some of his patients by accurately informing them that he possessed a cataract surgery certification that other area ophthalmologists did not have.

The State’s Amended Superceding Specification of Charges makes absolutely no mention of this alleged unprofessional conduct. For good reason: The American Medical Association’s Counsel on Ethical and Judicial affairs has issued a statement of AMA Policy which states that physicians who correctly tell patients that they have an exclusive or unique skill within their specific geographic area are well within the bounds of ethical conduct. The AMA Policy states, in relevant part:

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. . . . The key issue, however, is whether advertising or publicity, regardless of the format or content, is true and not materially misleading. The communication may include (1) the educational background of the physician . . . and (4) any other nondeceptive information. . . . Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, . . . are permissible.

E-5.02 Advertising and Publicity (attached hereto at Tab A).

This statement of AMA Policy makes clear that so far as physician advertising is concerned, the key consideration should be whether the practice in question was deceptive, either in its intention, or in its effects. Of course, no such showing can be made here. Dr. Chase’s truthful and accurate statements regarding his unique qualifications were not only accurate and therefore in no way deceptive, but also of the type of information regarding one’s medical practice that is specifically permissible under AMA Policy.

The undisputed evidence also demonstrates that Dr. Chase showed characteristic restraint in informing his patients regarding his qualifications. The American College of Eye Surgeons provides all of its accredited members with press releases and printed literature touting their membership. (Supp PF ¶ 662.) It suggests that certified physicians use this literature in order to promote their practices. (Supp PF ¶ 662.) Dr. Chase never used any of the literature provided to him by ACES, because he was totally opposed to advertising. (Supp PF ¶ 662.) In sum, Dr. Chase did not act unprofessionally, or bring pressure to bear on his patients, when he accurately informed them of his special certification. The State has neither charged nor proven otherwise.

3. Dr. Chase's Examination And Informed Consent Process Was Designed To Alleviate Pressure.

The State strenuously and successfully worked to prevent Dr. Chase from presenting all of his evidence regarding his informed consent procedures. The testimony of Dr. Chase's registered nurse, Ellen Flanagan, was excluded in its entirety. Brianne Chase was also precluded from testifying about the informed consent process. Now, after the close of evidence, the State argues for the first time that Dr. Chase's informed consent procedure was a mere afterthought and "formality" that played no relevant role in patient education or decision-making. The State cannot have it both ways.⁴ It must either concede that Dr. Chase's informed consent process was an effective and integral part of patients' surgical decisions, or it must allow Dr. Chase to present his overwhelming evidence of this position.

Even the limited evidence that was admitted shows that Dr. Chase's informed consent was anything but a formality. Instead, it was intentionally designed to alleviate the patient stress

⁴ The depth of the State's disingenuousness is stunning. If Dr. Chase had failed to provide his patients with a comprehensive informed consent, or had even provided an informed consent as scanty as that administered by most of the other testifying cataract surgeons, the Board can be certain that the State would point to that failure as unprofessional and indicative of a surgeon pressuring his patients into surgery. However, faced with evidence that Dr. Chase's informed consent was second to none, the State is left to argue that the informed consent process is not important at all. The State's argument is as transparent as it is wrong.

that inevitably accompanies surgical decisions and in fact provided patients with the breathing room they needed to make their decisions at their own pace and with all of the information they needed. After summarizing the risks and benefits of cataract surgery himself, Dr. Chase directed every potential cataract surgery patient to meet with his registered nurse for a preoperative teaching session. Some patients chose not to see the nurse, others scheduled appointments to see the nurse at a later time, and still others proceeded to talk with the nurse directly if their schedules allowed. The break between Dr. Chase's examination and the nurse's presentation offered patients their first opportunity to contemplate their surgical decision. For instance, Ms. Salatino was examined by Dr. Chase, then went to lunch with her husband (who had also had cataract surgery), before returning to meet with the nurse. (Supp PF ¶ 665.) Similarly, after being examined by Dr. Chase, Ms. Nordstrom scheduled her informed consent meeting for the following week. (PF ¶ 289.)

The fact that the detailed informed consent presentation was administered by someone other than Dr. Chase was another benefit to his patients. Dr. Jonathan Javitt, who conducted the single largest survey of cataract practices in the United States, testified that utilizing a registered nurse to deliver the detailed informed consent is an extraordinarily good practice because it allows the patient to weigh the risks and benefits of surgery outside of the physician's presence and implicit influence. (PF ¶ 222.) Dr. Freeman agreed that it is advantageous for a physician to delegate the informed consent process to a nurse, because some patients communicate more comfortably with a nurse than with a physician. (PF ¶ 221.)

The nurse spent between 1 and 1.5 hours with each patient, describing the surgery and helping patients understand their treatment choices and the consequences of those choices. (PF ¶ 204.) The nurse emphasized the elective nature of the surgery, both orally and in writing, and informed the patients that surgery was indicated only when they felt they were no longer seeing

well enough to function adequately. (PF ¶ 209-212.) Often, Dr. Chase and the nurse invited the patient's spouse or other relative to participate in the informed consent presentation. (*See, e.g.*, PF ¶ 337.)

Even then, Dr. Chase and his nurse did not require his patients to definitively decide whether to have surgery. Instead, the nurse sent the patients home with educational literature and the unsigned informed consent form, telling them to read it, think about it, and call with any questions they had. Dr. Chase did not allow, much less require, his patients to sign the informed consent form until they had taken advantage of this additional time of education and contemplation. (PF ¶ 211.) Instead, the patients were asked to sign the informed consent form on the morning of their scheduled surgery, and only after they had all of their questions and concerns addressed. (PF ¶ 211.)

The record evidence makes clear that Dr. Chase's patients took advantage of the breathing room that his informed consent process provided. For instance, Ms. Salatino decided in favor of surgery only after contemplating for five weeks whether her vision met her needs, reading the written material she had received, and discussing it with her husband. (PF ¶ 340.) Ms. Grigas called to cancel her scheduled surgery after going home and thinking about it for over one week. (PF ¶ 413.) Ms. Nordstrom scheduled, but decided not to return for, her informed consent meeting with the nurse. (PF ¶ 289.) Ms. Corning told the nurse that she wanted to discuss the surgery with her husband and would call back to schedule if she decided in favor of it. (PF ¶ 451.) Overall, a significant number of Dr. Chase's potential surgical patients decided not to move forward with surgery after meeting with the nurse and receiving the full informed consent presentation. (PF ¶ 220.)

This process, all of which is undisputed, is manifestly inconsistent with a physician who was pressuring his patients into having surgery that they did not want. To the contrary, it

provided every patient many opportunities to decide against surgery, and all of the information necessary to make that decision. There exists no rule or regulation that required Dr. Chase to provide his patients such an extensive informed consent. No other ophthalmologist in Vermont did so. Yet, Dr. Chase did. That fact is fundamentally inconsistent with the State's new allegation that Dr. Chase was intent on pressuring his patients into having surgery.

D. Dr. Chase Assessed His Patients' Functional Visual Deficits.

Throughout its Memorandum and Proposed Findings, the State alleges that Dr. Chase did not sufficiently assess his patients' functional vision before offering them cataract surgery, instead recommending surgery as soon as his examination revealed a whiff of a cataract and his patients had the most insignificant visual symptoms. Once again, the State's argument is not only uncharged, it ignores the bulk of the evidence, which shows that Dr. Chase systematically evaluated his patients' visual needs and symptoms, rather than employing a hair-trigger approach to surgery.

Dr. Chase assessed his patients' functional visual needs and deficits in many ways. As an initial matter, every patient filled out an Eye Health History questionnaire at the outset of every examination. That questionnaire asked patients whether they were currently experiencing any visual problems, including blurry vision and glare. (*See, e.g.*, PF ¶ 332.) Beginning in approximately 2002, each patient that had been previously diagnosed with cataracts was also asked to fill out a Lifestyle Questionnaire, on which she was asked to self-report any additional visual symptoms and assess the severity of those symptoms. (PF ¶ 115.) The technician conducted a personal interview with the patient, during which the technician asked the patient whether she was experiencing any visual difficulty. (PF ¶ 118.) The technician then assessed the patient's functional vision using CST and BAT testing, which provides a "more comprehensive" assessment of functional vision than Snellen visual acuity. (PF ¶ 121.) All of

this information was then presented to Dr. Chase, who further questioned the patient regarding her visual symptoms, using the technician's history, the patient questionnaires, and his physical examination to guide his inquiry. (PF ¶ 126.)

The evidence makes clear that Dr. Chase only offered surgery to his patients if, based on all of the information revealed by his examination, he concluded: (1) that the patient had cataracts; (2) that those cataracts were causing visual symptoms that could not be remedied through glasses but could be remedied through surgery; and (3) the severity of those symptoms was confirmed by CST with BAT scores that fell below patch 3 on the 6 c/d column of the VectorVision test, indicating a functional visual deficit that both the manufacturer of the test and the FDA deem significant. Indeed, it was not at all unusual for Dr. Chase to decline to offer surgery to patients with cataracts and visual complaints if, based on his experience and testing, he believed that the complaints were simply too minimal to be remedied by surgery. For instance, although Ms. Salatino was diagnosed with cataracts and complained of glare and/or difficulty driving at night in 1995, 1998, and 2000, Dr. Chase did not offer her surgery on any of those occasions. (PF ¶¶ 328-330.) Similarly, Dr. Chase diagnosed Ms. Grigas with cataracts in 1997, 1998, 1999, and 2000, but did not consider cataract surgery because her CST with BAT scores remained at or above normal despite her cataracts. (PF ¶¶ 401-05.)

The State points out that the second-opinion doctors, too, attempted to evaluate the complaining patients' functional vision in their own ways, and reached different conclusions regarding the significance of the patients' cataracts. However, not one of these physicians used a detailed lifestyle questionnaire. Not one of these physicians used contrast sensitivity. Most did not utilize glare testing of any sort. Many did not perform dilated slit lamp examinations. And at least one did not even test his patients' best corrected Snellen visual acuity. As a result, the Board cannot rely on any of these physicians' assessments to second-guess the considered

opinion of the only doctor who assessed his patients' functional vision in every way he knew how.

1. Dr. Chase's Use Of Questionnaires Was Appropriate.

Although the State attacks Dr. Chase's use of patient questionnaires as somehow illegitimate or impersonal, the American Academy of Ophthalmology specifically endorses their use for assessing patients' functional status, either in conjunction with or instead of a patient interview: "The assessment of functional status is a pertinent part of the patient's history and can be obtained by means of an *interview or a questionnaire*." (Supp PF ¶ 667 (emphasis added).) Indeed, unlike patient interviews or Snellen testing, questionnaires "provide a standardized approach to assess the patient's function, which can be analyzed and compared across time periods." (*Id.*) This is particularly true of disease-specific questionnaires, such as the Lifestyle Questionnaires used by Dr. Chase, which were based on peer-reviewed and published questionnaires designed for use with cataract patients. (*Id.*; PF ¶ 115.) Nonetheless, Dr. Chase always used his Lifestyle Questionnaires in conjunction with patient interviews conducted by him, his technicians, and his nurse.

Moreover, there is no evidence that Dr. Chase used his questionnaires as a sole basis or threshold for surgery, as the State contends. (State's Proposed Findings ¶ 6.) Rather, as discussed above, he used them in order to gather important information regarding his patients' functional status, which he then considered along with the totality of the information revealed by his examination, including the patients' slit lamp exam and CST with BAT scores.

2. Only The Patient Can Decide Whether Her Vision Is Bad Enough To Justify Surgery.

Perhaps sensing that it cannot undermine the substance of Dr. Chase's patient assessments, the State next attempts to attack the style in which he performed them, asking this

Board for the very first time to decree that every ophthalmologist must engage in an undefined “collaborative process” with a patient in order to determine if the patient’s vision is meeting her needs, and suggesting that Dr. Chase did not conform to that approach. (State’s Proposed Findings ¶ 6.) The State has invented its “collaborative process” standard out of whole cloth and has made no attempt to explain what it means. It appears, however, that the State is using this euphemism to suggest what it cannot allege directly: that doctors themselves must determine that their patients’ lifestyles are significantly affected by their vision before *offering*, rather than *performing*, cataract surgery.

As even the State is by now aware, this argument suffers from several fatal defects. First, it is contrary to the AAO PPP, which says that cataract surgery should not be *performed* unless the patient’s quality of life is sufficiently compromised by her vision that she is willing to assume the potential risks of surgery in order to gain its expected benefits. (PF ¶ 93.) Second, every ophthalmologist who was asked confirmed that only the patient, not the doctor, can make that decision. (PF ¶ 95.) Third, and perhaps most importantly, the patient can only decide if her lifestyle is sufficiently compromised *after* being offered the surgery and being educated regarding its risks and benefits. (PF ¶ 96.) Although the State refuses to accept this, its own witnesses—Drs. Cavin, Watson, Clearly, Morhun, and Guilfooy—agree. (PF ¶ 96.) The State’s continued insistence that a physician must divine whether his patients’ lifestyles are compromised before he even offers them surgery is not simply contrary to the AAO PPP and the State’s own evidence, it makes no sense.

E. Dr. Chase Allowed His Patients To Participate In Important Decisions Regarding Their Eye Care.

Piggybacking on its newfound arguments that Dr. Chase pressured his patients into surgery and failed to assess their true visual needs and function, the State contends for the first

time that Dr. Chase's practices resulted in "the removal of the patient from decisions regarding his or her health care." (State Memorandum at 8.) As demonstrated above, nothing could be further from the truth. Where Dr. Watson purposefully declined to tell his patients that they had early cataracts, (Supp PF ¶ 666), Dr. Chase felt that it was important for his patients to know that even early cataracts could affect their vision. Where Dr. Irwin felt that it was unimportant for him to tell Ms. Kerr that her cataracts caused her Snellen vision to decline five lines from 20/20 to 20/60 when subjected to the BAT on its medium setting, (PF ¶ 603-09), or to tell Ms. Corning that her Snellen vision dropped two lines under the same conditions, (PF ¶ 455), Dr. Chase informed his patients when their functional vision, as measured by CST and BAT, suffered a significant decline. Most importantly, where most of the State's testifying physicians simply told their patients when their cataracts were mature enough to be removed, Dr. Chase allowed his patients to decide for themselves when their cataract-induced vision loss was bad enough to justify surgery. In short, Dr. Chase was alone among the testifying Vermont ophthalmologists in trusting his patients enough to make their own decisions regarding surgery and providing them with all of the accurate and complete information they needed to make those decisions well.

F. The State Bears The Burden Of Proving That Dr. Chase's Practices Were Unprofessional, Not The Other Way Around.

Time and again throughout its Proposed Findings, the State argues that Dr. Chase "has not provided a satisfactory explanation" for his methods of recording patient visual symptoms, his manner of recording vision scores, his determinations that his patients' had visually significant cataracts, and his scribes' shorthand notations regarding "second opinions." (*See, e.g.,* State's Proposed Findings ¶¶ 21, 23, 25(f).) These arguments turn the standard of proof on its head. The State bears the burden of proving by a preponderance of the evidence that Dr. Chase's practices were unprofessional. It does not meet that burden by demonstrating that he did

things differently than other doctors. Instead, it must demonstrate that he violated an established rule of professional conduct. Until the State has done that, Dr. Chase has no obligation to provide any explanation for his practices, much less an explanation “satisfactory” to the State. As discussed at length in Dr. Chase’s Post-Trial Motion and Proposed Findings, the State has failed to prove that any of Dr. Chase’s practices were unprofessional. Nonetheless, as discussed below, Dr. Chase has provided medically, scientifically, and ethically sound explanations for all of his practices.

1. Dr. Chase Properly Recorded His Patients’ Visual Symptoms.

First, Dr. Chase explained that in recording his conclusions regarding his patients’ visual symptoms, he relied not only on what the patients told him, but on all of the information gleaned during his comprehensive evaluation. (PF ¶¶ 188-89.) It is both appropriate and good practice for an ophthalmologist to do what Dr. Chase did with respect to Ms. Kerr, Ms. Grigas, Ms. Lang and Mr. Touchette—to record in the “history” section of a chart the physician’s own conclusion regarding the patient’s functional vision symptoms based upon the entirety of the examination. (PF ¶¶ 45-47.) A physician’s recorded conclusions regarding the effect a cataract is having on the patient’s functional vision cannot be falsely made unless, at a minimum, they are unsupported by the information gleaned from the entire examination.

As set forth in detail in Dr. Chase’s Post-Trial Brief in section II.K.3, the conclusions recorded by Dr. Chase regarding the symptoms of these four patients were amply supported by the information gathered by him during his examinations. Sometimes his patients agreed with his assessment of their visual function. Sometimes they refused to acknowledge their deficits. But Dr. Chase’s conclusions were always strongly supported by the patients’ full medical record, including their CST with BAT scores. (PF ¶ 189, 266-617.)

Moreover, Dr. Chase never attempted to represent his own conclusions as direct quotations, or even paraphrases, from his patients. Both he and his technicians regularly used quotation marks to designate a direct quote. (Supp PF ¶ 668.) None of the allegedly falsified symptoms are accompanied by such a designation; nor are they phrased in the first person. In contrast, Dr. Morhun wrote a first person complaint in Ms. McGowan’s chart (without using quotation marks): “Dr. Chase said I needed cataract surgery OS—but my ADLs are not adversely affected.” (PF ¶ 522.) Under oath, he admitted that Ms. McGowan likely never actually said that her “ADLs were not adversely affected.” (*Id.*) Rather, although this complaint was phrased in the first person, it was Dr. Morhun’s conclusion based on what Ms. McGowan did tell him about her vision. (*Id.*) Similarly, Dr. Cavin wrote in Mr. Augood’s charts (without using quotation marks) that his glare symptoms were “more a nuisance than a problem.” (Supp PF ¶ 670.) Dr. Cavin admitted that this is likely not what Mr. Augood told him, but rather constituted his own characterization of the severity of the patient’s cataracts and complaints. (Supp PF ¶ 670.) All of the other doctors who were asked said that it is perfectly appropriate for a physician to synthesize all of the information revealed by an examination when recording his patients’ visual symptoms in the history section of the patients’ charts. (PF ¶ 190.) The State is attempting to hold Dr. Chase to an invented standard that even its own physician witnesses do not observe and asking him to provide a “satisfactory explanation” for actions that other doctors engage in every day, without any explanation at all.

Perhaps even more troubling than the State’s invented standard is its effort to add specific allegations of symptom falsification that are not charged in the Specification. In its Proposed Findings, the State urges the Panel to find that the visual symptoms recorded by Dr. Chase and his staff in the charts of Helena Nordstrom, Judith Salatino, and Franklin Cole were intentionally falsified. (State’s Proposed Findings ¶¶ 23, 36, 95.) The State did not charge these allegations in

its Amended Specification of Charges and, for that reason alone, the State's proposed findings with respect to these patients should be rejected. They should be rejected on the additional ground that they are completely meritless.

The State asks the Panel to adopt a finding that Dr. Chase knowingly made a false entry in Ms. Nordstrom's chart that she was unable to see clearly to drive at night. (State's Proposed Findings ¶ 23.) In fact, that particular entry was made by the technician or scribe, and there is absolutely no evidence that she falsified it. The entry made by Dr. Chase in the history section of the chart was "patient has constant blurred VA OS (left eye) from cataract this interferes with binocular VA." Dr. Chase's entry was completely consistent with the patient's charted complaints and her hearing testimony. Ms. Nordstrom testified that the Snellen chart appeared blurry to her when she was tested in Dr. Chase's office with her best corrected vision before dilation. (PF ¶¶ 271-72.) She also testified that her vision problems caused her more difficulty reading road signs and driving at night; and that she may have told the technician that vision in her left eye was darker than in the right. (PF ¶¶ 269-70.) Accordingly, both Dr. Chase's conclusion regarding the effect the cataract was having on Ms. Nordstrom's vision, and the complaint entered by the technician, were consistent with and supported by Ms. Nordstrom's medical record and her hearing testimony.

The State also urges the Panel for the first time to find that Dr. Chase falsified the entry on Judith Salatino's chart that she was "unable to see clearly to drive in glare HS (night)." (State's Proposed Findings ¶ 36.) Ms. Salatino's records reveal that she made this or similar complaints during several prior examinations by Respondent, (PF ¶¶ 328-30), and that during her June 11, 2003 examination, she reported in her own handwriting that she sometimes had difficulty seeing traffic signs and was bothered by poor night vision, seeing rings around lights, and seeing in glare and dim light. (PF ¶ 332.) These facts, along with Ms. Salatino's deficient

contrast sensitivity test results, (PF ¶ 333), justified Dr. Chase's recorded conclusion that Ms. Salatino could not see clearly to drive at night in glare. The State's proposed finding to the contrary also unscrupulously ignores the recording in Dr. Irwin's medical records of his July 25, 2003 examination of Ms. Salatino, stating that before her cataract surgery, Ms. Salatino "had been having trouble with night driving and distance vision in general." (PF ¶ 345.)

Franklin Cole reported at his July 15, 1992 examination by Dr. Chase that he was bothered by lights and did not like to drive at night, and these symptoms were recorded in the medical chart by Dr. Chase's technician. (PF ¶ 483.) Dr. Chase did not make the entries, and there is no explanation, let alone any evidence, as to why, as the State requests, (State's Proposed Findings ¶ 95), this Panel should find that the technician falsified these complaints to justify unnecessary surgery. Indeed, Mr. Cole testified at the hearing that at the time of his examination 14 years before the hearing, he recalled that he had been fearful of driving at night and was bothered by glare when doing so, although he explained that his fear was that animals would jump in front of his car from the side of the road. (PF ¶ 483.) In any event, the State's Proposed Finding ¶ 95 is uncharged and baseless, and it is irresponsible for the State to urge this panel to adopt it as fact.

2. Dr. Chase Properly Determined The Visual Significance Of His Patients' Cataracts.

Contrary to the State's representation, Dr. Chase has repeatedly explained how he determined whether a cataract was visually significant: He took into account not only the physical characteristics of the cataract, but also the patient's symptoms and her vision test scores, including her CST with BAT scores. (Supp PF ¶ 669.) This is exactly the multi-factored analysis by which the AAO PPP recommends that physicians determine the visual significance of their patients' cataracts. (PF ¶¶ 39-76.) It is also supported by the Beaver Dam Study, which

confirmed that the appearance of a cataract, taken alone, is a very poor indicator of the effect it will have on vision. (PF ¶¶ 161-62.)

3. **Dr. Chase’s Use Of The Word “Dense” to Distinguish Visually Significant Cataracts From Those That Did Not Adversely Affect Vision Was Appropriate, Was Not A False Statement, And Misled No One.**

Ignoring Dr. Chase’s evidence on the subject, the State continues to request the Board to find that Dr. Chase’s use of the word “dense” to identify cataracts that he concluded were having a significant effect on functional vision constituted a purposeful falsification of the medical records to justify unnecessary surgery. No doctor testified to that proposition, and all who were asked stated that it was acceptable for Dr. Chase to use the descriptor “dense” to identify visually significant cataracts if it facilitated his delivery of quality care to his patients. (PF ¶ 159.) Many of the testifying doctors used unique descriptors whose significance was seemingly clear only to the individual physician. Dr. Cavin used the phrase “quite clear” to mean a lens was cloudy but not significantly so, (PF ¶¶168); Dr. Cleary used “haze” to describe an unspecified type of cataract, (PF ¶ 167); Dr. Irwin used numerical grades with shifting meanings that only he was aware of. (PF ¶¶165.) Although all of these unique descriptions helped the individual doctor who used them, none meant anything to other doctors or insurers, as the physical appearance of a cataract provides little if any insight into how the cataract will affect functional vision. (PF ¶¶ 160-62.) Accordingly, no doctor relies on another doctor’s recorded physical description to make any material treatment decision. (PF ¶ 183.)

The State forebodingly warns that permitting ophthalmologists to mix subjective and objective descriptions of cataracts will promote standardless record keeping. (State’s Memorandum at 7.) The State does not suggest what standard the Panel should adopt or explain why, if its own position is sound, the AAO itself has not adopted such universally applicable

standards. Furthermore, the evidence is clear that virtually all the ophthalmologists who testified in this case inject a subjective evaluation of a cataract's effect on vision into their physical description of the cataract. (PF ¶¶ 180-82.) Indeed, some doctors, such as Drs. Irwin and Watson, include a subjective component in their very definition of cataract, and will not diagnose a lenticular opacity or color change to be a cataract unless they believe it is having an effect on functional vision. (PF ¶ 169.)

If mixing subjective and objective descriptors is unprofessional, as the State contends, then it is unprofessional every time a doctor fails to diagnose a lens opacity as a cataract because it has no effect on functional vision, or when a doctor uses "quite clear" to mean cloudiness of the lens that is visually insignificant. The unrebutted testimony was that virtually all of the rating scales and unique adjectives doctors employ to describe cataracts are highly subjective and nebulous in meaning to other doctors. (PF ¶ 164.) Mixing objective and subjective descriptions of cataracts during medical charting is a result of the manner in which ophthalmology gathers and evaluates information, and it is perfectly appropriate so long as it assists the physician in delivering care to the patient. (PF ¶ 180.)

Finally, for Doctor Chase's use of the word dense to describe cataracts to be false, it must be contradictory to some established meaning of the word dense recognized by all ophthalmologists. It is generally agreed, however, that the word dense has no single meaning among ophthalmologists. Dr. Irwin testified he does not use the word dense because it has no precise meaning, while Dr. Cavin uses the word to signify to himself both how the cataract might affect vision and how difficult the cataract may be to extract during surgery. (PF ¶¶ 181-82, 166.)

In short, Dr. Chase's use of the word dense was significant and helpful to him in treating his patients, and no other physician or knowledgeable person would have relied upon it to make a material decision.

4. Dr. Chase Properly Recorded His Patients' Functional Vision In His Charts.

In erroneously asserting that Dr. Chase's charting of test results constituted purposeful falsification, (State's Memorandum at 4-5; State's Proposed Findings ¶¶ 8, 25, 39), the State displays a fundamental misunderstanding of the basic concepts underlying vision and its testing. Dr. Chase measured the visual acuity, contrast sensitivity and glare components of his patients' vision by subjecting them to both Snellen and CST with BAT testing. (PF ¶¶ 119-33.) He was the only testifying doctor from Vermont who tested the contrast sensitivity component of his patients' vision, and he was also the only one to regularly employ glare testing as a diagnostic and evaluative tool for cataract patients. (PF ¶ 146.) All of Dr. Chase's objective test results were prominently located together on the inside cover of the patient medical record where they could easily and quickly be reviewed and compared to each other. (PF ¶¶ 142-45.) On the pre-printed chart form, located in the middle of his medical record, he often recorded his cataract patients' CST with BAT score, tested after their best corrected visual acuity had been determined through refraction, beside the pre-printed heading "1. vision. V". (*Id.*)

Notwithstanding the relatively clear state of the evidence, the State begins its unwarranted attack on Dr. Chase's testing by wrongly contending that entering the CST with BAT score beside "Vision" was misleading and that deception was Dr. Chase's motive in placing it there. The State, without explanation or logic, wrongly argues that only the visual acuity component of vision can be charted under "Vision" and not the CST with BAT component. In fact, it was entirely proper for Dr. Chase to record CST with BAT by the

“Vision” heading because he believed it was most reflective of the patient’s overall or functional vision. (PF ¶¶ 142-43.) His belief was not a novel concept outside of Vermont, as the AAO PPP expressly states that contrast sensitivity is a more comprehensive measure of cataract patients’ functional vision than Snellen vision, and ophthalmologists and vision scientists with expertise in this area agree with Dr. Chase that contrast sensitivity is particularly well suited to measure visual disability induced by cataracts. (PF ¶ 59-63.) It correlates more closely with patients’ self described cataract symptoms than Snellen testing, and it is more effective in detecting functional vision impairments caused by cataracts. (PF ¶¶ 61-63.)

Far from being covert or deceptive, Dr. Chase openly communicated the importance he attached to CST with BAT in evaluating the effects of cataracts on functional vision: 1) he informed insurance companies as early as 1995 that CST with BAT was a better measure of functional vision than Snellen (PF ¶ 154) and explained why he recorded the CST with BAT score beside vision (PF ¶ 154; Ex. 522); 2) he routinely and expressly emphasized CST with BAT over Snellen scores on chart summaries sent to other ophthalmologists and physicians (PF ¶ 153); and he discussed with patients their CST with BAT scores in explaining their functional vision impairments. (PF ¶¶ 374, 407.) In short, he openly and extensively communicated the importance he attached to CST with BAT to doctors, patients and insurers.

When Dr. Chase placed a CST with BAT score beside the letter “V” on his chart as being most reflective of the patient’s vision, he would also place the same score directly beneath it and next to the patient’s refraction, labeling it as CST with BAT to show that it was obtained using the patient’s best possible refraction. (PF ¶ 145.) In wrongly claiming that Dr. Chase misleadingly entered a CST score to reflect a patient’s best corrected visual acuity, the State badly conflates related but very different concepts. (*See, e.g.*, State’s Memorandum at 4-5; State’s Proposed Findings ¶¶ 25, 39.) Visual acuity is a component of vision usually measured

by use of the Snellen test; just as contrast sensitivity is a component of vision measured through contrast sensitivity testing; the effect of glare on vision can be measured by using a BAT with either a Snellen or CST chart. (PF ¶¶ 8, 50-76.) Because no single test measures all components of vision, doctors often use a test of a particular visual component as being most reflective of functional vision. Dr. Chase frequently used the CST with BAT test score as the score most reflective of his cataract patients' functional vision, *not* as the State contends, as indicating the visual acuity component of his patients' vision. The other Vermont ophthalmologists who testified used only the Snellen visual acuity test and thus recorded only that visual component as reflecting the patients' overall vision functioning. Although Dr. Chase was different from other Vermont ophthalmologists in recording CST with BAT as most reflective of functional vision, he was also practicing more consistently with the most recent ophthalmological learning and advances in this area.

The State also confuses basic facts regarding ophthalmological testing when it erroneously suggests in its proposed findings that Dr. Chase determined the patients' best corrected vision under glare conditions and after dilation. (*See, e.g.*, State's Proposed Findings ¶¶ 8, 25, 39, 45.) Determining a patient's best corrected vision involves refracting a patient to determine the spectacle prescription that best corrects any refractive error in the patient's eye. It is undisputed that refracting the patient both before and after dilation permits the physician to give the best, most accurate prescription and avoid any error in the refraction process (and thus the spectacle prescription) due to any ability the patient may have to accommodate. Dr. Freeman testified that he always refracts patients scheduled for refractive surgery both before and after dilation to obtain the most accurate refraction possible (because a surgically implemented refraction is not as easily changed as a pair of glasses), and Dr. Javitt likewise confirmed the efficacy of refracting both before and after dilation to obtain the most accurate prescription. (PF

¶ 55.) In any event, no ophthalmologist disagreed that a patient's best corrected visual acuity, as measured on the Snellen chart, would be the same both before and after dilation if, as Dr. Chase did, the patient was refracted both before and after dilation. (PF ¶ 56.) The State's own evidence confirms this fact: The results of the Snellen testing performed by the State's testifying ophthalmologists, which was almost always performed pre-dilation, often conformed exactly or very closely to the results of Dr. Chase's post-dilation Snellen testing of the same patients. For instance, Dr. Chase measured Jane Corning's post-dilation Snellen visual acuity as 20/20 in the right eye and 20/25 in the left. Dr. Irwin measured Ms. Corning's Snellen vision before dilation, and also recorded it as 20/20 in the right eye and 20/25 in the left. (Supp PF ¶ 678.)

None of Dr. Chase's patients were ever refracted subject to glare or had their visual acuity, as opposed to contrast sensitivity, tested with glare. The State's argument to the contrary represents either a complete misunderstanding or willful misrepresentation of the evidence.

It also bears re-emphasizing that the State's arguments regarding which Snellen test score Dr. Chase recorded is a red herring, as the Snellen scores of the State's complaining patient witnesses did not figure significantly in Dr. Chase's decision to offer surgery or in the AAO PPP's criteria for surgery. Indeed, Dr. Chase's charts plainly reflect that many of the complaining patients had very good Snellen vision. Instead, the objective test results that Dr. Chase relied upon most in evaluating the effect of a cataract on functional vision was CST with BAT, and that test was always taken while the patient wore trial frame glasses with lenses determined after a refraction that provided the patient's best corrected Snellen visual acuity. (PF ¶ 122.)

The State relies on snippets of testimony, removed from their proper context, from several Vermont ophthalmologists to create the misguided impression that these doctors faulted Dr. Chase's methods of refracting patients and his use of CST with BAT as an evaluative and

diagnostic tool. It quotes Dr. Cavin, (State's Proposed Findings ¶ 8(a)), as explaining how to obtain a patient's best corrected visual acuity, but neglects to mention that Dr. Cavin does not refract his cataract patients and thus does not determine their best corrected visual acuity. (PF ¶ 152.) It quotes Dr. Guilfoy, (State's Proposed Findings at ¶ 8(b)), for the unremarkable proposition that he, like Dr. Chase, determines a patient's best corrected visual acuity through refraction and Snellen testing. The State quotes Dr. Irwin, (State's Proposed Findings ¶ 8(d)), for the point that he relies on Snellen testing without glare or dilation because he wants to determine a patient's real life vision. Although Dr. Chase also tests visual acuity using Snellen without glare or dilation, he recognizes that Snellen test results are artificial as they are performed in a darkened room, with a brightly lit, high-contrast chart. Dr. Irwin's own medical records for Jan Kerr underscore the artificiality of Snellen testing by showing that her visual acuity tested at 20/20 in a darkened exam lane but fell precipitously to 20/60 when tested under conditions simulating outdoor lighting on a partly cloudy day. (PF ¶¶ 603, 609.)

In sum, Dr. Chase used no glare in determining a patient's best corrected visual acuity. He used dilation only to ensure that the undilated refraction was not compromised by any accommodative power of the patient. His patients all received a CST with BAT test before dilation and with their best refraction to ensure that the test was not affected by correctable refractive error. Dr. Chase used CST with BAT as the best reflection of his patient's overall functional vision, not as representing the visual acuity component of their functional vision.

5. Dr. Chase Properly Recorded His Own Refraction, Rather Than That Performed By A Technician.

Dr. Chase also acted properly when he placed the results of his own refraction, rather than the refraction performed by the technician, in his patients' charts. Unlike all of the other doctors who testified, Dr. Chase's office performed three refractions, and therefore took three

best corrected Snellen visual acuity scores for every patient as part of every complete examination. The first refraction, taken by a computerized autorefractor, was helpful as a starting point for the technician's manual refraction, but was not perfectly accurate, particularly with respect to cataract patients. (Supp PF ¶ 672.) The second refraction, a manual rather than automated refraction, was performed by a technician prior to dilation. (PF ¶ 120.) It is difficult to perform a proper refraction. Ophthalmologists take a full year course to learn how to do it well. (Supp PF ¶ 673.) As a result, Dr. Chase insisted on re-performing his patients' manual refraction during his portion of the examination. By the time Dr. Chase examined the patient, the patient was dilated to facilitate a complete examination of the back of the eye and paralyze their ability to accommodate. Dr. Chase therefore performed his manual refractions, and obtained a third best corrected Snellen score, after his patients' eyes were dilated. (PF ¶ 128.) As discussed above, the practice is common and proper. Dr. Chase would compare his refraction and vision score to those achieved by the technician and the autorefractor. He then recorded a single Snellen vision—normally the one that he, the doctor, obtained through his own refraction—directly in the chart, discarding the technician's preliminary result in order to avoid later confusion. (PF ¶ 130.) Dr. Javitt testified that there is nothing wrong with this practice, and that he, too, discarded his technician's preliminary test scores, which he directed them to record on post-it notes. (Supp PF ¶ 677.) Many other ophthalmologists do the exact same thing. (*Id.*) This is simply no evidence that it is unusual, much less improper.

6. No Reasonable Person Would Be Misled By The Scribes' Shorthand Notation, "Second Opinion Given."

The State continues to contend that "any reasonable reader" would conclude that the scribe's shorthand notation "second opinion given" indicates that Dr. Chase's patients were provided with a second opinion by another doctor as to the need for cataract surgery during the

course of Dr. Chase's exam. However, the State still refuses to identify exactly who might have been misled in this manner. Dr. Chase's scribes and technicians understood the meaning of this notation; in fact, they invented it, (PF ¶ 197), to record the fact that Dr. Chase told each patient that if she went to any other medical eye doctor and said she came for a second opinion regarding cataract surgery, she would be told that if she saw well enough to suit her, it would not damage her eyes not to have the surgery. (PF ¶ 194.) There is no evidence that any patient, physician, or insurer even read, much less was misled or confused by, this notation. No doctor can provide his patients his own second opinion, and no reasonable person would interpret this single line in Dr. Chase's charts to mean otherwise.

Moreover, nearly every other doctor to testify utilized shorthand descriptions that could be potentially confusing, even misleading, to the uninitiated reader. As noted above, Dr. Cavin used the shorthand description "quite clear" to designate a lens that had an early opacity, and was therefore *not* quite clear. (PF ¶ 168.) Dr. Watson would indicate that his patients did *not* have cataracts as long as he believed that their lens opacities were not significantly affecting their vision. (PF ¶ 169.) Of course, according to the AAO PPP, a lens opacity *is* a cataract, regardless of its effect on vision. (PF ¶ 19.) The State has not suggested that these doctors' charting idiosyncrasies, however misleading on their face, amount to purposeful falsification. The Board cannot legitimately apply a different standard to Dr. Chase.

G. Dr. Chase Explained His Treatment Of Every Patient.

The State's contention that Dr. Chase failed to rebut the allegations of professional misconduct because he "did not take the stand in his own case to offer a counter-explanation to the testimony of the eleven patients" is nothing short of bizarre. (State's Memorandum at 4.) As the Board is well aware, the panel allowed Dr. Chase to explain his treatment of each patient, and to address each patient's complaints, during the State's case-in-chief. He testified for five days

regarding the complaining patients. Like every ophthalmologist who testified, he based his testimony largely on the patients' records and on his general practices, rather than on a specific recollection of the 13 particular patients out of the tens of thousands he has treated. The State is free to ignore that testimony, but the Board is not.

H. Dr. Freeman's Testimony Is Valid And Convincing.

Of all of the ophthalmologists who testified, Dr. James Freeman was the only one who based his opinions on all of the medical charts from all of the ophthalmologists who treated all of the patients. In contrast, none of the State's testifying ophthalmologists was asked to review Dr. Chase's charts or to take account of the complaints the patients voiced to Dr. Chase or the vision scores he measured. Nonetheless, the State predictably attempts to discount Dr. Freeman's opinion by falling back on its original allegation that Dr. Chase's charts were falsified and are therefore not reliable. This argument suffers from a fatal flaw: Dr. Freeman demonstrated that, unlike the State, he accurately understood exactly what the entries in Dr. Chase's charts meant.

For instance, Dr. Freeman understood the manner in which Dr. Chase performed his Snellen and CST with BAT testing, as well as the way he recorded it in his charts. (Supp PF ¶ 671.) Dr. Freeman also understood that Dr. Chase used the descriptor "dense" to designate cataracts that were visually significant, rather than physically dense. (Supp PF ¶ 671.) He correctly interpreted Dr. Chase's notation of "second opinion given" to mean that Dr. Chase had delivered the first portion of his informed consent presentation. (Supp PF ¶ 671.) In fact, the State has not cited a single instance in which Dr. Freeman actually misinterpreted Dr. Chase's charts. His opinions are not only valid, they are the only opinions based on a thorough review of all of the information regarding each of the complaining patients.

I. The State Misrepresents The Evidence Relating To Individual Patients.

In addition to committing the systematic errors described above, the State also badly mischaracterizes the evidence, or the probative value of the evidence, pertaining to individual patients. Two of the most egregious examples are discussed below.

1. Dr. Chase Did Not Tell Ms. Nordstrom Not To Seek A Second Opinion.

Citing only Ms. Nordstrom's hearing testimony, the State contends that Dr. Chase explicitly told her that she should not seek a second opinion and that he was the only doctor who could perform cataract surgery. (State's Proposed Findings ¶ 10.) As demonstrated below, Ms. Nordstrom's testimony is too unreliable a basis on which to rest a finding of unprofessional conduct against Dr. Chase.

Ms. Nordstrom demonstrated significant unreliability as a witness, admitting on many occasions that she had previously testified falsely while under oath and contradicting her own sworn hearing testimony on many occasions. For instance, she first testified that Dr. Chase had given her free eye drops out of a basket at the front desk; she later admitted that there was no such basket, but that the eye drops were simply laying about the office in many locations; she later testified that the free eye drops were freely available in drawers. (PF ¶ 318.) In fact, all of the eye drops were in a locked cabinet and were unavailable to patients without Dr. Chase's permission. (*Id.*) Ms. Nordstrom also contradicted herself and her prior sworn testimony in describing why she even needed eye drops from Dr. Chase, first testifying that they were for her rabbit, then for her mother, and finally for her own dry eyes, despite her prior sworn testimony that she did not have dry eyes. (PF ¶ 321; Supp PF ¶ 674.)

Similarly, at her deposition, Ms. Nordstrom testified under oath that Dr. Chase told her to get a glucose tolerance test "in relation to the cataract surgery." (Supp PF ¶ 675.) At the

hearing, and also under oath, Ms. Nordstrom first testified that Dr. Chase did *not* tell her why he had ordered the blood sugar test, stating: “I did not understand the relation.” (*Id.*) She later testified that he did explain the relationship, (*id.*), only to again reverse course and say, “He did not tell me.” (*Id.*) She finally settled on her original answer, stating: “Okay. It was related.” (*Id.*)

Ms. Nordstrom also demonstrated a faulty memory of many details of Dr. Chase’s interaction with her. For instance, she claimed that Dr. Chase pointed to a plaque on his office wall demonstrating his special certification in cataract surgery. Photos of Dr. Chase’s office, *taken by federal authorities after his summary suspension*, show that no such plaque existed. (PF ¶ 319.) Finally, Ms. Nordstrom demonstrated significant bias toward Dr. Chase during her hearing testimony, at one point spontaneously and unprovokedly shouting at Dr. Chase about his purported inability to treat her mother’s dry eye condition and yelling at him “do you remember her.” (PF ¶ 317.)

Like many of the complaining witnesses, Ms. Nordstrom cannot be relied upon to accurately recall and recount the details of her examination by Dr. Chase. Unfortunately, it is those very details that form the basis of the State’s case. In assessing the State’s proof, the panel members must ask themselves whether they would be comfortable resting their own professional fates and personal reputations on the memory and testimony of Ms. Nordstrom.

2. Ms. McGowan Was Not Dilated Two Or Three Times.

For the very first time, the State alleges, on the strength of Ms. McGowan’s testimony alone, that her contrast sensitivity was measured after she was dilated two, or even three times. Once again, there is no such allegation in the Amended Superceding Specification of Charges. Moreover, the record shows that all of Ms. McGowan’s CST with BAT scores were obtained before she was dilated at all. On direct examination, Ms. McGowan testified with great certainty

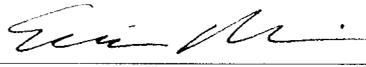
that she had received two sets of dilating drops prior to her CST with BAT in 1999 and three sets prior to her CST with BAT in 2003. However, on cross examination, Ms. McGowan admitted that she had no idea whether the various eye drops she had been given were for the purpose of dilating her eyes, rather than for some other legitimate diagnostic purpose, such as numbing her eyes in order measure her intraocular pressures or placing dye in her eyes to see how well it cleared, both regular parts of an exam. (PF ¶ 511.) Moreover, the evidence makes clear that in those rare instances where Dr. Chase repeated CST with BAT after dilation, both test scores were recorded in the patient's chart. (PF ¶ 132.) Ms. McGowan's chart contains only one CST with BAT test result for each visit. (Supp PF ¶ 676.)

III. CONCLUSION

In evaluating all of the evidence, the Board must keep in mind that the State has alleged, and must prove, that Dr. Chase recommended cataract surgery that he *knew* was inappropriate and that he *purposefully* falsified his medical charts regarding his patients' cataract care. It cannot attempt to add charges or theories not set forth in the Amended Superceding Specification of Charges. Nor can it prevail by proving anything less than the purposeful and intentional unprofessional conduct that it has alleged. The State cannot meet its burden, because there is not a shred of evidence that suggests, much less proves, that Dr. Chase believed that his patients were inappropriate surgical candidates or that he intended to mislead anyone with his charts. To the contrary, all of the evidence strongly supports only the conclusion that Dr. Chase honestly believed that his treatment recommendations and charting methods were in the very best interests of his patients. As a result, the State cannot prevail on any of its claims.

Dated at Burlington, Vermont, this 16th day of March, 2007.

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E-5.02 Advertising and Publicity

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive. Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading. The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other nondeceptive information. Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive. Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients. Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients. Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met. (II) Issued prior to April 1977; Updated June 1996.

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