

**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 PROPOSED FINDINGS OF FACT AND LAW

By this Order, the Hearing Panel of the Vermont Medical Practice Board (the "Board") recommends that the full Board find in favor of the Respondent, Dr. David S. Chase, on all charges contained within the State's Amended Superceding Specification of Charges in the above-captioned matter. In support of its recommendation, the Panel relies upon the following findings of fact and law, and urges the full Board to adopt those findings in support of its decision.

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INDEX OF TRIAL TESTIMONY

Hearing Date	Witness
09/11/06	Openings, David S. Chase
09/12/06	David S. Chase
09/21/06	David S. Chase
09/25/06	David S. Chase
09/26/06	David S. Chase, Franklin Cole
10/02/06	Susan Lang, Donald Olson, Joseph Touchette
10/03/06	Jan Kerr, Margaret McGowan, Jane Corning
10/23/06	Helena Nordstrom, Thomas Cavin, M.D.
10/24/06	William Augood Pierson, Edwin Guilfooy, M.D.
10/26/06	Judith Salatino, James Watson, M.D.
11/08/06	Karen Cleary, M.D., Marylen Grigas
11/20/06	Alan Irwin, M.D.
11/30/06	Geoffrey Tabin, M.D.
12/04/06	Patrick Morhun, M.D.
12/18/06	James Freeman, M.D.
01/04/07	Lydia Chobot, Arthur Ginsburg, Marcella Fulmer, Gloria Gil
01/08/07	James Freeman, M.D. (completion), David Evans, Ph.D.
01/09/07	Betty Morwood, M.D., Maureen Heath, Robert Vautier, Lynda Douglass
01/30/07	Jonathan Javitt, Brianne Chase
02/08/07	Closing Arguments

FINDINGS OF FACT AND LAW

I. THE RESPONDENT

1. Dr. David Chase is 70 years old. He resides in Shelburne, Vermont with his wife of 47 years, Brianne Chase. They have three adult children and three grandchildren. (Brianne Chase at 161-62.)

2. Dr. Chase is an ophthalmologist. He was raised in Littleton, New Hampshire by his mother, a schoolteacher. (Chase, 9/26/06 at 41-42.)

3. Dr. Chase graduated from the University of Vermont Medical School in 1962 and completed his medical internship at the New York Upstate Medical Center in Syracuse in 1963. Dr. Chase then volunteered for the United States Navy, where he practiced general internal medicine for two years. He completed his three-year ophthalmology residency at the University of Indiana in 1968. (Chase, 9/11/06 at 116.)

4. Dr. Chase opened his own medical office and practiced ophthalmology in Burlington, Vermont for 37 years until July 21, 2003, when the Vermont Board of Medical Practice summarily suspended his medical license. (Chase, 9/11/06 at 116.)

5. Dr. Chase had a general ophthalmology practice specializing in cataract surgery. (Chase, 9/12/06 at 23-25.)

6. Dr. Chase generally saw about 30 patients per day and performed 250-300 cataract surgeries annually. (Chase, 9/12/06 at 70.) This was comparable to the practice patterns of other general ophthalmologists in Vermont who specialized in cataract surgeries. (Cavin at 153 (400 cataract surgeries per year); Tabin at 40 (250 cataract surgeries per year); Irwin at 31-34 (300 cataract surgeries per year).)

7. Because Dr. Chase performed more testing of patients than other Vermont ophthalmologists, and provided lengthier more detailed informed consents, he employed more persons (technicians, scribes, nurses, an optometrist) than other Vermont ophthalmologists to assist him in delivering care to patients. (See ¶ 113 to ¶135 below; Ex. 760.)

II. VISION

8. Vision has been described as having multiple components, including distance visual acuity, contrast sensitivity, and peripheral vision, among others. (Ex. 503B, AAO PPP at 9; Freeman, 12/18/06 at 84-85.)

9. Distance visual acuity, often called Snellen vision, designates a person's ability to discern small black letters or numbers on a bright white background; it is measured using the black and white "Big E" chart familiar to most people. (Chase, 9/11/06 at 125.)

10. Snellen visual acuity does not measure contrast sensitivity, which provides the patient with the ability to discern objects of varying contrast, luminescence, and spatial frequency, which characterize most objects existing in the real world. Contrast sensitivity provides persons with the ability to perceive the edges of both large and small objects, and to distinguish them from their surroundings or background. (Ex. 503B, AAO PPP at 14; Ginsburg at 52-53.)

11. Visual function plays an important role in physical function, particularly in terms of mobility. Having blurred vision more than once or twice a month has a significant impact on functional status, interfering with work or other daily activities. (Ex. 503B, AAO PPP at 9-10; Morhun at 17, 117-18.)

12. Visual impairment, in particular a decrease in visual acuity and contrast sensitivity, has been shown to be associated with difficulties in driving; older drivers with visually significant cataract were twice as likely as older drivers without cataract to report reduction in days driven and four times as likely to report difficulties in challenging driving situations; drivers with visually significant cataract were 2.5 times more likely to have had an at-fault involvement in a motor vehicle crash in the past 5 years compared with drivers without cataract. (Ex. 503B, AAO PPP at 10.)

13. Drivers with a history of crash involvement were eight times more likely to have a serious contrast sensitivity deficit than those who had no history of crash involvement. (*Id.* at 10.)

14. Decreased contrast sensitivity is an important risk factor for falls and for hip fracture and decreased contrast sensitivity independently increases the risk of hip fracture. Loss of contrast sensitivity impairs a person's ability to discern edges, and thus they may not see steps, curbs or other unevenness in a surface. (Ex. 503B, AAO PPP at 9; Javitt at 18, 74-75.)

15. The loss of visual function in the elderly is associated with a decline in physical and mental functioning, as well as independence in activities of daily living, including night-time driving, daytime driving, community activities, and home activities; elderly patients with visual

impairment only were 2.5 times as likely to experience functional decline than elderly patients without visual impairment. (Ex. 503B, AAO PPP at 9.)

16. Cataract surgery is a very cost effective method of improving the health and quality of a patient's life. A Medicare patient who suffers from vision loss costs Medicare twice as much per year as the patient who does not have vision loss. Those costs are associated with falls, fractures, depression, and admission to nursing homes, among other things. (Javitt at 24-25, 74-75, 130-32.)

III. CATARACTS

17. The human eye employs a compound lens system to focus light on the retina, which in turn transmits information through the optic nerve to the brain; together, the eyes and the brain make up the visual system. (Ginsburg at 42-48.)

18. The two lenses of the eye are the cornea and the crystalline lens. About one-third of the eye's refractive power is in the lens and the remainder is in the cornea; but the lens' ability to flex, or change shape, permits persons to change focus to see near objects sharply. Both the cornea and the crystalline lens must be clear if light is to focus properly on the retina. (Freeman, 12/18/06 at 59-60, 62-64.)

19. A cataract is a degradation of the optical quality of the crystalline lens of the eye through loss of clarity or change in color. (Ex. 503B, AAO PPP at 3.)

20. The crystalline lens of the eye is composed of three concentric layers; some ophthalmologists describe those three layers through analogy to an avocado:

- (a) the nucleus of the lens is at the very center of the lens, like the pit at the center of an avocado;
- (b) the cortex of the lens surrounds the nucleus on all sides, like the flesh surrounding the pit of the avocado;
- (c) the capsule of the lens is a thin membrane that surrounds the cortex on all sides, like the hard green skin on the outside of the avocado. (Freeman, 12/18/06 at 61.)

21. Cataracts can occur in any of these three portions of the lens, and are therefore referred to as nuclear cataracts, cortical cataracts, and subcapsular cataracts. (Ex. 503B, AAO PPP at 4.)

22. A nuclear cataract is a central opacification, coloration or degradation in the nucleus of the lens. (*Id.*) A nuclear cataract is also sometimes referred to as a nuclear sclerosis. (Tabin at 44; Cavin at 162; Watson at 127-28.)

23. A cortical cataract, which can be located central or peripheral to the visual axis through the lens, is sometimes best appreciated with retroillumination rather than the direct illumination provided by a slit lamp. (Ex. 503B, AAO PPP at 4; Cavin at 163-64.)

24. Subcapsular cataracts may occur on either the anterior or posterior portion of the capsule, but because they usually occur on the posterior portion of the lens they are commonly referred to as posterior subcapsular cataracts. (Freeman, 12/18/06 at 64.)

25. A type of opacity known as a water cleft or water vacuole can also sometimes form in the lens of the eye due to changes in a patient's blood sugar level. (Tabin at 44-46; Cavin at 165.) A water cleft is a cataract, albeit one that may be transient. (Morhun at 43; Freeman, 12/18/06 at 108-10; Chase, 9/11/06 at 196.)

26. According to the State's own ophthalmologist witnesses, Drs. Geoffrey Tabin, Thomas Cavin and Patrick Morhun, as well as the Respondent's experts, Dr. James Freeman and Dr. Jonathan Javitt, although water vacuoles have the appearance and cause the same symptoms of normal cataracts, including loss of contrast sensitivity and blurry vision, they can appear and disappear as the patient's blood sugar level rises and falls. (Tabin at 44-46; Cavin at 164-65; Morhun at 43-44; *see also* Freeman, 12/18/06 at 108-10 and Javitt at 52-53.)

27. Some cataracts, particularly those that are caused by disturbances in the composition of the lens (sometimes called "oil droplet" cataracts because they resemble a drop of oil on water; both are clear, but each has a different refractive index) rather than a change in the color of the lens. Oil droplet cataracts can cause fluctuating vision, so that the patient experiences intermittent rather than constant blurry vision. (Freeman, 12/18/06 at 73-74, 78-79; Freeman, 1/8/07 at 48-52.)

28. Cataracts are usually bilateral, but do not always develop at the same rate in both eyes of a single patient. (Tabin at 46; Morhun at 35.)

29. All types of cataracts are capable of scattering light within the eye; they thus prevent the light from focusing properly on the retina, thereby causing more profound visual disabilities in sub-ideal lighting situations such as problems with glare or seeing in dim light. (Cavin at 164; Watson at 141; Morhun at 40-41; Ginsburg at 53-56.)

30. Cataracts can cause patients a variety of visual symptoms, including reduced Snellen visual acuity, reduced near vision, glare disability, reduced contrast sensitivity, altered color vision, and vertical diplopia, among others; a patient may experience one or more of these symptoms without experiencing the others. (Cavin at 182-86; Watson at 141-43, 168; Cleary at 21-23; Tabin at 51-52; Morhun at 61-63.)

31. 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 luminescences—before they experience a significant reduction in their Snellen vision—the ability to perceive dark black letters or numbers on a bright white background. As a result, cataracts can cause objects to appear “washed out” even though they are in focus and therefore not blurry. (Morhun at 77-78; Ginsburg at 53-54; Evans at 163-64.)

32. 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. (Morhun at 60-61; Ginsburg at 55-56.)

33. Due to these cataract-related symptoms, patients often complain of problems such as difficulty with glare and functioning in bright light, difficulty functioning in dim light, difficulty driving, difficulty driving at night, seeing starbursts around lights, and blurry distance, near, and intermediate vision, among other things. (Cleary at 24; Tabin at 51-52; Morhun at 61; Ginsburg at 55-56.)

IV. THE EVALUATION OF CATARACTS

34. Evaluation of a cataract involves two fundamental determinations: (a) determining whether a cataract exists and, if so, (b) determining what if any impairment it causes to the patient’s functional vision.

35. The ophthalmologist’s examination to evaluate cataracts consists of three basic components: (a) physical examination of the lens to determine the existence of a cataract; (b) taking a subjective history of the patient to determine whether she is experiencing visual symptoms that may be caused by the cataract; and (c) performing testing to diagnose visual impairments not appreciated by the patient and to quantify impairments.

A. Determining The Existence Of Cataracts

36. Ophthalmologists diagnose cataracts by using a microscopic device with a light, called a slit lamp, to look into the eye through the pupil and examine the lens of the eye.

(Freeman, 12/18/06 at 74-75; Chase, 9/25/06 at 23-25; Morhun at 48.)

37. Because the undilated pupil is only about 3 millimeters in diameter, and the normal lens is 13 millimeters, an ophthalmologist cannot view most of the lens of the eye unless the patient's pupils are first dilated. Dilation also enhances the quality of the view of the lens seen through a slit lamp. As a result, it is absolutely necessary to dilate a patient's eyes before performing a complete cataract evaluation, or ruling out the presence of cataracts. (Chase, 9/25/06 at 22; Cavin at 167; Watson at 131-32; Morhun at 49; Freeman, 12/18/06 at 124-25.)

38. However, many cataracts, in particular water clefts and oil droplet cataracts, are not easily discernable through the slit lamp because they are disturbances, rather than discolorations, in the lens. (Javitt at 83.) These types of cataracts are best appreciated by bouncing light off the back of the eye, a process called retroillumination. (Ex. 503B, AAO PPP at 4.) Retroillumination is normally performed with an instrument called a direct ophthalmoscope; it cannot be properly performed with a slit lamp. (*Id.*; Freeman, 12/18/06 at 74-80; Freeman, 1/8/07 at 48-56.)

B. Determining And Recording Patient's Cataract Symptoms

39. An ophthalmologist can take a patient history through patient interviews, patient questionnaires or both. (Ex. 503B, AAO PPP at 12-13.)

40. It is important to realize that patients adapt to their visual impairment and may fail to notice a functional decline because the development of cataract may be very insidious. (Ex. 503B, AAO PPP at 9; Cavin at 188, 261; Watson at 140; Cleary at 25-26; Tabin at 54-55; Javitt at 63.) It is also important to realize that not all patients who do recognize their visual impairment complain of that impairment to their ophthalmologists or their ophthalmologists' staff, often because they are anxious about the prospects of surgery or their authority to perform specified tasks, e.g. licensed driving. (Javitt at 64-65; Morhun at 63.)

41. Some patients are more comfortable sharing their symptoms with the ophthalmologist than a technician, and vice versa. (Watson at 124.)

42. It is well established in scientific literature that patients often do not accurately remember what their visual symptoms were prior to surgery. (Javitt at 65-67.)

43. As a result, it is appropriate for ophthalmologists to use cataract-specific patient questionnaires in order to help patients identify and report visual symptoms due to cataract; the use of such questionnaires is endorsed and encouraged by the AAO and the American Society of Cataract and Refractive Surgeons. An ophthalmologist is entitled to rely upon the symptoms reported on such questionnaires. (Ex. 503B, AAO PPP at 13; Cavin at 201; Cleary at 27; Tabin at 56-60; Javitt at 68-69.)

44. Cataract-related questionnaires are often the best measure of patients' visual function prior to cataract surgery, and they are much more reliable than the patients' post-surgical recollection of pre-surgical symptoms. (Javitt at 68, 65.)

45. According to both Dr. Chase and the State's doctor witnesses, it is perfectly acceptable and professional for an ophthalmologist and his technicians to paraphrase their patients' complaints and to record their own understanding of the patients' symptoms based on everything revealed during the course of the examination by the patient, her vision testing, and the eye doctor's physical exam. (Chase, 9/11/06 at 175; 9/12/06 at 109-11; Cavin at 202-03; Irwin at 203; Javitt at 118-19.)

46. It is both acceptable and good practice for an ophthalmologist to add his or her own conclusions regarding the patient's symptoms and to record those additions in the "history" section of the patient's chart during the course of an examination. (Cavin at 204-05; Javitt at 118-19; Irwin at 7-8, 77-88; Freeman, 1/8/07 at 83.)

47. It is also appropriate for an ophthalmologist to record his or her conclusions regarding patient symptoms in the "history" section of the chart, regardless of when during the examination those symptoms were revealed and whether or not the patient acknowledges the symptoms revealed by vision testing. (Freeman 12/18/06 at 104-05, 1/8/07 at 83; Irwin at 8-9, 203; Ex. 501-JS-2-001; Cavin at 204-05; Watson at 124-25; Javitt at 118.)

48. A physician's conclusions regarding his patient's symptoms are not false unless they are unsupported by the information revealed by the entirety of the examination.

C. Vision Testing And Cataracts

49. Because patients do not always recognize or report their visual symptoms, the impact of cataract on visual function should also be assessed through vision testing. (Freeman, 12/18/06 at 101-02, 135; Irwin t 55-56.)

50. There is no single way to measure patients' vision, and the impact of cataract can be assessed through measures that include contrast sensitivity, glare disability or visual acuity. (Ex. 503B, AAO PPP at 12; Freeman, 12/18/06 at 85.)

1. Snellen Testing

51. Visual acuity testing, often called Snellen vision testing, measures a patient's ability to discern objects in a high contrast, ideal lighting environment, i.e., to see black letters or numbers on a white background with sources of glare eliminated by dimming ambient lighting and with the chart well illuminated. The Snellen test is a very poor measure of the patient's contrast sensitivity, or how they see in the real world where they must discern objects of varying contrast, luminescence, and spatial frequency in varying lights conditions. (*Id.* at 14; Ginsburg at 57-58; Tabin at 62-63; Morhun 75-77; Cavin at 197.)

52. Several former patients of Dr. Chase testified who had excellent Snellen vision but also at the same time had visually disabling losses of contrast sensitivity and/or glare problems that adversely affected the quality of their life until cured by successful cataract surgery. (Chobot at 10-21; Morwood at 8-20; Gil at 159-62; Heath at 30-38; Douglass at 62-69; Fullmer at 137-148.)

53. Snellen vision testing was invented in 1862 as a means of prescribing glasses to patients; it is expressed as a fraction (e.g. 20/20 or 20/40); a patient who sees 20/20 has normal Snellen vision, while a patient who sees 20/40 must be 20 feet from the Snellen chart in order to discern the letters that a normal person can see at 40 feet. (Chase, 9/11/06 at 125.)

54. In order to obtain a patient's best corrected Snellen visual acuity ("BCVA"), an ophthalmologist or his staff must refract a patient while the patient views the Snellen chart. Refraction is the process of changing the patient's corrective lenses until the patient's ability to view the Snellen chart is optimized. (Chase, 9/11/06 at 154-55.)

55. In order to obtain the most accurate refraction for a patient, the doctor or technician must perform both a dilated and undilated refraction. (Javitt at 56.) Physicians who trained at the time Dr. Chase was trained were always taught to refract their patients in a dilated and undilated state in order to obtain the most accurate possible refraction. However, in order to improve efficiency, many doctors have abandoned the practice of re-refracting patients after dilation. It nonetheless remains the "gold standard" of refraction, (Javitt at 55-57), and is still

commonly used by physicians to obtain the most precise refraction prior to refractive surgery. (Freeman, 12/18/06 at 112-15.)

56. In a patient with a normal eye, as long as a patient is re-refracted after dilation, he or she should normally achieve the same best corrected Snellen visual acuity score both before and after dilation. (Chase, 9/11/06 at 183; Javitt at 57; Morhun at 199-200; Freeman, 12/18/06 at 112-15.)

57. If a patient achieves a better or worse Snellen score after dilation, that fact is often indicative of ocular pathology (such as a visually significant cataract or irregular astigmatism) warranting further investigation by the eye doctor; as a result, post-dilation refraction is a helpful diagnostic tool. (Javitt at 58-59; Morhun at 101-02.)

58. A patient's Snellen vision score may be affected by many factors independent of refractive error or eye disease, including but not limited to the amount of ambient light in the examination lane, the type of chart used, and how hard the ophthalmologist or technician "pushes" the patient to see the letters on the chart; as a result of these and other factors, a patient may achieve different Snellen scores in different physicians' examination lanes. (Chase, 9/12/06 at 38; 9/26/06 at 38-39; Cavin at 196-97; Watson at 144-45; Tabin at 61-62; Morhun at 74.)

2. Contrast Sensitivity Testing

59. Contrast sensitivity testing ("CST") measures the eye's ability to detect subtle variation 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. In the patient who complains of visual loss and has lens changes, contrast sensitivity testing may demonstrate a significant loss of visual function not appreciated by Snellen testing of visual acuity. (Ex. 503B, AAO PPP at 14; Cavin at 198; Watson at 163; Cleary at 35; Morhun at 79.)

60. Reduced contrast sensitivity may cause patients to have difficulty seeing in low-contrast situations such as driving at night, discerning where the grey pavement ends and the grey shoulder begins, or distinguishing the edges of stair treads. (Watson at 150-51; Cleary at 36-37; Ginsburg at 56-59; Evans at 166.)

61. CST results correlate more closely with patients' self-described cataract symptoms than do Snellen visual acuity scores (Ex. 819, Beaver Dam Study; Watson at 151-52; Evans at 165); 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 and seeing to drive safely at night. (Ginsburg at 36-37; Evans at 163-54, 166.)

62. As a result, CST is a better measure than Snellen acuity of visual disability caused by cataracts, and by early cataracts in particular because it identifies cataract induced vision loss earlier than Snellen testing. (Freeman, 12/18/06 at 101-02; Morhun at 87-88; Evans at 164-66, 177.)

63. The Beaver Dam Study confirms that early lens opacity diminishes contrast sensitivity and patient-reported quality of life before it affects Snellen visual acuity. (Javitt at 121; Ex. 819.)

64. Although there are several valid methods of testing patients' contrast sensitivity, the FDA has endorsed the precise contrast sensitivity test method employed by Dr. Chase, a sine wave-based test manufactured and designed by VectorVision, for cataract evaluation. (Evans at 169; Freeman, 12/18/06 at 85-87.)

3. Glare Testing

65. Glare testing determines the degree of a patient's visual impairment caused by a light source not located directly in the patient's sight line. Cataracts may cause severe visual disability in brightly lit situations such as ambient daylight or lighting at night (e.g., headlights and streetlights). Visual acuity in some patients with cataract is normal or near normal when tested in a dark examination room, but when these patients are re-tested using a source of glare, visual acuity (or contrast sensitivity) drops precipitously. (Ex. 503B, AAO PPP at 14; Cavin at 193, 197; Watson at 162; Cleary at 30-31.)

66. The most common standardized method to simulate glare in an office setting is the Brightness Acuity Tester ("BAT") manufactured by Mentor; the BAT provides a highly standardized way of simulating glare. Dr. Chase used the BAT. (Ex. 615, BAT; Ex. 515, BAT Manual; Freeman, 12/18/06 at 102-04; Evans at 171.)

67. Unlike unstandardized methods such as use of a pen light, which produce disabling point sources of light aimed directly into patients' eyes, the BAT produces a hemisphere of light through which the patient can view an eye chart. (Morhun at 109.)

68. Most practitioners use the BAT either on its medium setting, which simulates a partly cloudy day, or its high setting, which simulates ambient light produced by overhead sunlight. (Evans at 173; Javitt at 83-85; Ex. 515, BAT Manual at 1.)

4. Combining Contrast And Glare Testing

69. It is appropriate to use CST and BAT together in order to evaluate a cataract patient's functional vision. (Ex. 503B, AAO PPP at 14; Cavin at 194; Evans at 172.) In fact, the inventor of Dr. Chase's Vector Vision CST device, Dr. David Evans, testified that his CST is most commonly used with the BAT. (Evans at 172.)

70. According to the State's own witnesses and the American Academy of Ophthalmology, CST and BAT are legitimate parts of a cataract evaluation. (Ex. 503B at 14; Cleary at 35; Morhun at 85-88, 108-09.)

71. Glare and contrast sensitivity testing often reveal significant real-life, cataract-related visual deficits that are not detected by Snellen testing. (Cavin at 193, 197; Watson at 162, 167-68; Evans at 164.) Indeed, The FDA also requires the manufacturers of new intraocular lenses and other devices to test them using CST and glare. (Ginsburg at 63-64; Freeman, 12/18/06 at 85-87.)

72. It is medically appropriate to perform glare testing, and to use the BAT, after a patient's eyes are dilated. (Javitt at 61; Ginsburg at 86-87; Cavin at 155-56; Ex. 515, BAT Manual.) The BAT product manual specifically contemplates that an ophthalmologist may re-perform BAT testing after dilation to determine if functional vision improves or worsens with dilation. (Ex. 515, BAT Manual at 2; Morhun at 111; Evans at 192.) Reasons to do so include simulating real life conditions such as when persons are subjected to glare during night driving when their pupils are dilated. (Freeman, 12/18/06 at 116-17.)

73. When a driver confronts oncoming headlights at night, those headlights will not cause the driver's pupils 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. (Javitt at 59-61; Freeman, 12/18/06 at 116-17.) 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. (Evans at 190-91.)

74. In the absence of an ocular abnormality, such as a visually significant cataract, dilation will not materially affect the CST/BAT scores of most patients subjected to BAT.

(Evans at 184.) 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. (Evans at 189-90.) A physician may thus gain valuable diagnostic information by re-performing CST and BAT after dilation. (Evans at 188-91.)

75. 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; for instance, Jan Kerr performed two CST/BATs on November 20, 2002. (Ex. 501-JK-1-010, 011.) There was virtually no difference between her pre- and post-dilation test scores. (*Id.*; Chase, 9/21/06 at 213-15.)

76. Of all of the ophthalmologists who testified, Dr. Chase was the only one who used contrast sensitivity testing in evaluating the 11 complaining patients. Since this case began, the State's single paid expert witness, Dr. Patrick Morhun, has begun using CST in evaluating his cataract patients because, as he testified, using CST: "[M]akes me a better doctor." (Morhun at 260.) Nonetheless, the State did not ask any of the complaining patients to have their contrast sensitivity or glare vision evaluated by another physician prior to the hearing in this case.

V. CATARACT SURGERY AND ITS BENEFITS

77. Cataract surgery is the most commonly performed surgery in the United States; in 1999, 1.6 million cataract procedures were performed on Medicare recipients alone. (Ex. 503B, AAO PPP at 8.)

78. As late as the 1970s, most physicians performed cataract surgery through a large incision that opened the entire eyeball and removed the whole natural lens of the eye. Most patients were immobilized for weeks following surgery, required thick "cataract glasses," and never regained normal pre-cataract vision. (Javitt at 69-73; Freeman, 12/18/06 at 45-46.)

79. Today, the preferred method of cataract surgery is extracapsular extraction through phacoemulsification followed by capsular fixation of an appropriate intraocular lens ("IOL"). (Ex. 503B, AAO PPP at 18-19; Cavin at 217; Javitt at 69-73.)

80. The physician performs phacoemulsification using a high powered microscope and microscopic tools. The physician makes one or two tiny incisions. Through those incisions, he emulsifies the cataractous lens of the eye using a specialized instrument. That same instrument then extracts the emulsified lens, leaving intact the capsule that holds the lens in place. (Morhun at 55-56.)

81. Through the same incision, the ophthalmologist then inserts a synthetic IOL to replace the natural cataractous lens. The IOL is specifically calculated to provide the patient with optimal uncorrected distance vision, eliminating or lessening the need for glasses—even in patients who were formerly nearsighted or farsighted. (Freeman, 12/18/06 at 61-66.)

82. Cataract surgery performed by a skilled ophthalmologist takes as little as six minutes, or as long as 30 minutes, from incision to closure. (Cavin at 15; Tabin at 67.)

83. Normally, the patient is awake during the operation, and is subject only to topical or local anesthesia. (Cavin at 218; Tabin at 67-68.)

84. In the United States, most cataract surgery is performed in an ambulatory surgical center setting; the patient walks in and out of the surgery within a few hours. (Tabin at 41.) Patients may return to their daily activities within a day. (Tabin at 41; Cavin at 218.)

85. Well-performed cataract surgery is safe and highly effective in eliminating or ameliorating all vision problems caused by cataract. In addition, it usually corrects pre-existing refractive error in the eye unrelated to the cataract and often eliminates the need to wear glasses. (Ex. 503B, AAO PPP at 11; Cavin at 217-19; Morhun at 140; Ginsburg at 60-61.)

86. Physical function, emotional well-being, and overall quality of life can be enhanced when visual function is restored by cataract surgery. (Ex. 503B, AAO PPP at 11.)

87. A cataract surgeon is reimbursed less than \$650 dollars by Medicare for cataract surgery. (Cavin at 220; Javitt at 630-31.)

88. Cataract surgery is the single most cost-effective surgery among the elderly that has ever been measured. (Javitt at 24.) It generally provides a patient with high quality vision for life at a relatively small cost to the health care system. (*Id.*)

89. Dr. Chase performed between 250 and 300 cataract surgeries per year in the 10 years preceding the summary suspension of his license. Dr. Cavin performs about 400 cataract surgeries per year. (Cavin at 153.) Dr. Morhun performs about 700 per year. (Morhun at 28-29.) High volume cataract surgeons in other parts of the country may perform several thousand cataract surgeries per year. (Tabin at 40.)

VI. THE STANDARD FOR PERFORMING CATARACT SURGERY

90. Cataract surgery is almost always an elective procedure: the patient must decide whether her visual defects justify undergoing the procedure. (Javitt at 76-77; Morhun at 118-19.)

91. Cataract surgery is appropriate when the patient’s “visual function no longer meets the patient’s needs and . . . cataract surgery offers a reasonably likelihood of improvement.” (Ex. 503B, AAO PPP at 15; Freeman, 12/18/06 at 67-68.)

92. If cataracts cause difficulty with any task important to the patient—whether it is recreational, occupational, or otherwise—that difficulty is sufficient to justify cataract surgery if the patient desires. (Cavin at 262; Morhun at 123.) In the face of such complaints, the ophthalmologist does not also need to explicitly ask each patient, “Is your lifestyle compromised?” (Cavin at 263.)

93. Cataract surgery should not be *performed* where the patient does not desire surgery, where glasses or visual aids provide vision that meets the patient’s needs, or where the patient’s quality of life is not compromised by his or her vision. (Ex. 503B, AAO PPP at 15-16 (emphasis added).)

94. Patients’ attitudes and reactions to being diagnosed with cataracts and/or offered surgery vary widely. Some accept it matter of factly and some are greatly disturbed by such news. (Freeman, 12/18/06 at 131-35; Irwin at 59.)

95. The physician can determine whether a cataract impairs vision, but only the patient can decide when her visual symptoms interfere with something she wants to do to a degree such that she is willing to undergo cataract surgery to remedy them. (Cavin at 208-10; Cleary at 53; Watson at 160; Chase, 9/25/06 at 90; Javitt at 77-78; Morhun at 119.)

96. 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. (Cavin at 209-10; Watson at 170, 177; Cleary at 53; Chase, 9/25/06 at 90-92; Morhun at 119; Guilfooy at 179-80.)

97. Thus, consistent with the standard of care, it is appropriate for a physician to provide a patient with the choice of cataract surgery when: (1) the patient has cataracts; (2) the patient complains of symptoms that the doctor attributes to the cataracts; (3) glasses are unlikely to resolve the symptoms; and (4) cataract surgery offers a reasonable likelihood of improving the patient’s vision. (See, e.g., Cavin at 209; Watson at 160-61, 178; Morhun at 118; Ex. 503B, AAO PPP at 15-16.)

98. Summarizing this standard, it is proper to offer cataract surgery as an option to a patient if the ophthalmologist concludes that the patient has a visual problem that is caused by

the cataract that can be fixed by cataract surgery, (Javitt at 76; Tabin at 66; Watson at 178, 181), so that the patient can then decide if the visual symptom is compromising her lifestyle to a degree that causes her to want it fixed through surgery.

99. In deciding whether or not to have surgery, a person does not need to wait until her cataracts 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].” (Cavin at 211-12, 262; Watson at 160; Morhun at 123-24.)

100. 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. (Irwin at 261; Cavin at 231; Watson at 177-78; Cleary at 54; Morhun at 119-20 Javitt at 80.)

101. A cataract patient’s pre-operative Snellen visual acuity is a poor predictor of postoperative functional improvement; therefore it is medically inappropriate to condition cataract surgery upon the patient failing to meet a threshold score, such as 20/40 Snellen visual acuity. (Ex. 503B, AAO PPP at 13; Cavin at 208; Javitt at 93; Tabin at 64.)

102. A cataract does not need to reach a certain appearance, grade, or level of maturity, before surgery is warranted, as a physician cannot tell how a cataract will affect a patient’s vision simply by the appearance of the cataract. (Cavin at 177; Freeman, 12/18/06 at 100-01; Morhun at 53.)

103. 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. (Javitt at 81-82.)

104. Even early cataracts can cause patients to experience significant visual symptoms, and those symptoms can justify surgery. (Freeman, 12/18/06 at 127-28; Javitt at 83; Cavin at 177, 181; Cleary at 50; Irwin at 41, 106; Morhun at 126-30; Ex. 819, Beaver Dam Study.)

105. The standard for performing cataract surgery has evolved as the safety and efficacy of the procedure have increased. For instance, in the 1970s and 1980s, many physicians would not perform cataract surgery, and many insurers would not pay for it, until a patient’s Snellen vision had fallen below a certain threshold, such as 20/50 or 20/40. (Watson at 81.)

106. Today, it is acceptable for ophthalmologists to perform cataract surgery on patients who see 20/20 or 20/25. (Cavin at 212; Tabin at 19,54-65; Javitt at 70-74; Freeman, 12/18/06 at 81-83.)

107. The State's own witnesses, Dr. Cavin and Dr. Tabin, will perform surgery on a patient with 20/20 Snellen vision if they conclude that the patient has symptoms – such as glare, trouble driving at night, or difficulty reading – that will be remedied by cataract surgery. (Cavin at 276-77; Tabin at 19, 54-65.)

VII. DIFFERENT DOCTORS APPLY THE AAO STANDARD DIFFERENTLY

108. Good, competent doctors can reasonably disagree as to when the AAO PPP standard has been met as to a particular patient. (Cavin at 214; Tabin at 65; Morhun at 124.)

109. Some good, competent doctors will offer surgery as soon as the patient voices complaints that the doctor attributes to cataracts and cannot be fixed with glasses; others will wait until the patient's complaints become worse. (Morhun at 124.)

110. Some doctors, such as Dr. Guilfooy, reject the AAO standard and use a Snellen threshold to determine when cataract surgery is appropriate. Dr. Guilfooy uses a general Snellen threshold of 20/40 and an absolute Snellen threshold of 20/30. Thus, if a patient has 20/30 or better Snellen vision, Dr. Guilfooy will not perform cataract surgery regardless of the seriousness of the patient's visual impairment and regardless of how profoundly the impairment interferes with the patient's life. (Guilfooy at 212-13, 221, 224, 231.)

111. Dr. Irwin is still reluctant to operate on a patient with 20/20 Snellen vision and, of the 8-9,000 of cataract surgeries he says he has performed, he has performed only two on patients with 20/20 Snellen vision. (Irwin at 89.)

112. There are regional differences in how conservative or aggressive cataract surgeons are. New England tends to be conservative. Dr. Chase's practices, while progressive in Vermont, would be deemed conservative in Florida or California; persons in those areas may "say he is not operating soon enough." (Javitt at 73.)

VIII. DR. CHASE'S ROUTINE EXAMINATION OF CATARACT PATIENTS

113. Dr. Chase performed an extensive examination of every cataract patient.

114. First, each patient was asked to fill out an Eye Health History form, on which the patient was asked to self-report her medical history and visual symptoms. (Chase, 9/11/06 at 147.)

115. Beginning in approximately 2002, each patient that had been previously diagnosed with cataracts was also asked to fill out a Lifestyle Questionnaire, on which he or she was asked to self-report any visual symptoms. (Chase, 9/11/06 at 147; 9/12/06 at 207.) The Lifestyle Questionnaire used by Dr. Chase is based on a published, peer reviewed questionnaire, and is an effective tool to identify and document cataract-induced visual defects. (Javitt at 68-69.)

116. Both the Eye Health History form and the Lifestyle Questionnaire were filled out by the patients before they saw Dr. Chase. (Chase, 9/11/06 at 147.)

117. Dr. Chase's technicians took each patient's blood pressure in order to identify any underlying hypertension. (Chase, 9/11/06 at 148.) Dr. Javitt testified that this practice was unusual in ophthalmology and was very good. It is indicative of a physician who was concerned about his patients' overall health, not just their eyes. (Javitt at 44-45.)

118. Dr. Chase's technicians then interviewed the patients regarding their visual symptoms, noting any reported symptoms in the chart and placing quotations around exact quotes from patients. (Chase, 9/12/06 at 62, 106, 130.) The State has not suggested or presented evidence that the technicians' notations regarding patient complaints were false or falsified.

119. After interviewing the patient, the technician normally measured the patient's vision using an autorefractor; this measurement served as a starting point for the technician's manual refraction of the patient using a Snellen chart. (Chase, 9/26/06 at 43.)

120. The technician then gave each patient a pair of trial glasses frames with their best refraction in order to provide the correct amount of panoscopic tilt to the patient's spectacles while recording the patient's best corrected Snellen visual acuity. This refraction was performed prior to dilating the patient and the results were normally recorded on a sticky note or on the autorefractor slip which was placed on the front of the patient's chart. (Chase, 9/11/06 at 147, 149-50.)

121. Using the trial frames, the technician measured the patient's contrast sensitivity, utilizing the VectorVision CST and simulating glare by use of the Brightness Acuity Tester ("BAT") set on high, which simulated ambient light on a sunny day with the sun overhead. (Chase, 9/11/06 at 132-33, 139-41; Ex. 515, BAT Manual at 1.) The technician recorded the results of this test on the VectorVision CST slips, indicating that the results were obtained using

simulated glare, and placed those slips prominently inside the front cover of the patient's chart. (Chase, 9/11/06 at 147.)

122. Dr. Chase's technicians performed all of the CST and BAT testing; Dr. Chase did not perform it himself. (Chase, 9/11/06 at 130; 9/12/06 at 115; 9/21/06 at 21.) The technicians always tested the patient's CST with BAT vision utilizing the trial frames with lenses that provided the patient with his or her best corrected visual acuity. (Chase, 9/11/06 at 147; 9/12/06 at 151.) The technician always tested the patient's CST with BAT vision prior to dilation. (Chase, 9/11/06 at 147; 9/12/06 at 150; 9/21/06 at 21.)

123. The methods of testing contrast sensitivity and glare utilized by Dr. Chase's technicians, and relied upon by Dr. Chase, conform to the FDA's standards for contrast sensitivity and glare testing and are scientifically and medically valid and reasonable means of evaluating functional vision loss from cataract. (Ginsburg at 63-66; Evans at 175, 193-94; Freeman, 12/18/06 at 92.)

124. Dr. Chase's technicians measured the patient's IOP, then dilated the patient prior to Dr. Chase's examination.

125. Dr. Chase's staff took automated visual field measurements as part of every full examination, which is the single best way to identify patients with early glaucoma. (Chase, 9/11/06 at 148.)

126. Dr. Chase further questioned his patients regarding their symptoms as appropriate, using their patient questionnaires, the technician's history and their CST with BAT and Snellen test results to guide his questioning. (Chase, 9/11/06 at 173; 9/12/06 at 208; 9/21/06 at 63.)

127. Dr. Chase performed a full physical examination of each patient's dilated eyes using his slit lamp to look at the inside of the patient's eye through the dilated pupil. He also examined most patient's lenses through retroillumination, utilizing his direct ophthalmoscope. (Chase, 9/11/06 at 162-63.)

128. Although each patient was refracted at least twice by the technician, Dr. Chase re-refracted every patient a third time to determine their best corrected visual acuity after dilation using the Snellen chart. (Chase, 9/11/06 at 150; Chase, 9/26/06 at 43.)

129. In contrast, none of the State's testifying ophthalmologists performed a manual refraction of their patients more than once and some did not perform any, even if they were recommending cataract surgery. (Cavin at 228.)

130. Dr. Chase would compare his refraction to the autorefractor and to that achieved by the technician prior to dilation; after considering both pre- and post-dilation Snellen scores, he determined and recorded a single Snellen score on the top of the CST slip in the chart. (Chase, 9/11/06 at 150-51.) Usually, Dr. Chase's Snellen score did not differ from that achieved by the technician prior to dilation. (Chase, 9/11/06 at 153.)

131. On unusual occasions—less than 5% of the time—Dr. Chase would ask his technicians to re-test the patient's CST with BAT vision. Re-testing occurred only when (1) based on the patient's history and his own physical examination, Dr. Chase suspected the first test results were erroneous or (2) he wanted to measure the patient's CST with BAT vision under circumstances that correlated more closely with nighttime activities, when the patient's pupils were large. (Chase, 9/11/06 at 158-59; 9/12/06 at 75.) Dr. Chase never re-performed the test himself, just as he never performed the initial CST himself. (Chase, 9/12/06 at 147-48.)

132. The results of the second CST/BAT test were also recorded on VectorVision CST slips and placed in the chart. (*See* Ex. 501-SL1-1-068, 69; 501-JK-1-010, 011.)

133. Through his exam, as demonstrated by his records, he specifically eliminated potential causes of visual symptoms other than cataracts before offering cataract surgery. (Ex. 501; *see e.g.*, Ex. 501-HN-1-002; Chase, 9/26/06 at 57-59; Irwin at 42-43.)

134. Dr. Jonathan Javitt, M.D., M.P.H., conducted the largest study of cataract surgery practices in the United States. He testified that Dr. Chase's patient exams were extraordinarily thorough and exhibited many of the very best practices utilized by cataract specialists around the country, including the regular use of contrast sensitivity testing, the regular use of glare testing, multiple dilated and undilated refractions and measurements of Snellen visual acuity, and an emphasis on achieving perfect vision after cataract surgery. (Javitt at 41, 126-27.) He testified that Dr. Chase's practice was the type of practice to which he would send his loved ones (Javitt at 126-27.)

135. Dr. Javitt testified that Dr. Chase's practice exhibited none of the hallmarks of overly aggressive cataract practices, including high volume advertising, busing nursing home patients for surgery, performing cataract surgery the same day as the cataract diagnosis, the lack of a meaningful informed consent process, and the lack of a complete examination prior to surgery. (Javitt at 42-43.)

A. Dr. Chase's Decision To Offer Cataract Surgery

136. When considering whether or not to offer a patient surgery, Dr. Chase took into consideration all of the information he learned during the course of the patient's examination, including the patient questionnaires, the patient's complaints to the technician and to him, his physical examinations, and the results of the patient's vision testing. (Chase, 9/21/06 at 21, 114.)

137. Dr. Chase did not offer patients cataract surgery unless: (1) they had cataracts; (2) they complained of visual symptoms attributable to cataracts; (3) the symptoms were caused by the cataracts and could not be eliminated with new glasses; and (4) his objective vision testing, such as CST/BAT, confirmed the patient's subjective symptoms. (Chase, 9/26/06 at 57-59.) On many, many occasions, Dr. Chase diagnosed patients with cataracts but did not offer them surgery because they were not complaining, or because the symptoms voiced by the patients were not sufficiently severe, even if the patient's CST/BAT results were well below normal. (See e.g., Chase, 9/21/06 at 17, 25, 82-86; 9/25/06 at 99, 136; Lang at 58-59.)

138. On many, many occasions, Dr. Chase diagnosed patients with cataracts but did not offer them surgery because they were not complaining, or because the symptoms voiced by the patients were not sufficiently severe, even if the patient's CST/BAT results were well below normal (See, e.g., Chase, 9/21/06 at 17, 25, 82-86; 9/25/06 at 99, 136; Lang at 58-59.)

139. On other occasions, Dr. Chase diagnosed patients with cataracts, but their CST/BAT scores indicated that their visual function was not badly compromised, and he did offer them surgery. (Ex. 501-MG-1-050, 016.)

* 140. Excluded Exhibit 650 analyzes all patients on whom Dr. Chase performed cataract surgery in the 3 year and 6.5 month period between January 1, 2000 and July 21, 2003, and excluded Exhibit 651 analyzes all patients who were initially diagnosed with cataracts during the same period who were not offered cataract surgery. The exhibits do not include patients initially diagnosed before January 1, 2000 with cataracts and not offered surgery. The charts show:

- a) Dr. Chase performed cataract surgery on 612 patients and 1125 eyes during this period, the surgery patient's average age was 63, the average time between diagnosis and the offer of surgery was 3.5 years, and the average CST patch score was 1.63 (Ex. 650); and

- b) Dr. Chase diagnosed cataracts but did not offer surgery in 818 patients and 1632 eyes during the same period. Their average CST w/BAT patch score was 3.15. (Ex. 651.)

141. The evidence presented by the State shows that Dr. Chase did not offer cataract surgery to any patients unless their cataract related complaints were corroborated by CST/BAT scores of patch 3 or below when measured at 6 c/d on the VectorVision test, which was significantly below normal. (Chase, 9/21/06 at 61; 9/26/06 at 57-59.)

B. Dr. Chase's Methods Of Recording His Patients' Vision Scores

142. For each of the eleven complaining patients, Dr. Chase measured the patient's Snellen vision and recorded it in the chart, usually on the test slip that also contained the patients' CST with BAT results. (Chase, 9/11/06 at 178; 9/12/06 at 147; Ex. 501-HN-1-013; 501-JS-1-064; 501-SL1-1-068; 501-MG-1-047; 501-DO-1-001; 501-JC-1-017; 501-FC-1-011; 501-MM-1-018; 501-JT-1-009; 501-WA-1-002; 501-JK-1-011.)

143. The vision test slip containing each patient's Snellen and CST/BAT results was affixed prominently within the inside cover of each patient's chart, along with any visual acuity scores obtained through use of an autorefractor. As a result, all of the patient's vision test scores were in a single prominent place in the chart. (See Ex. 501, original patient charts; Chase, 9/11/06 at 180; 9/12/06 at 148-49; 9/21/06 at 95; Freeman, 1/8/07 at 84-85.)

144. In addition to recording all vision scores within the front cover of the patient's chart, Dr. Chase would place the vision score that most accurately reflected the patient's real life functional vision (either Snellen or CST/BAT) next to the preprinted letter "V," on the first page of his examination notes for each particular patient visit. (See, e.g. Chase 9/11/06 at 183-85; 9/12/06 at 119; 9/21/06 at 108-10; 9/26/06 at 59-62; 9/25/06 at 97-98.)

145. If a CST w/BAT score were placed by the "V," Dr. Chase would also place the patient's CST/BAT result immediately after the patient's refraction on the same page just beneath the "V," clearly labeling it "CST/BAT" to show that it was the result of the patient's best possible refraction. (Chase, 9/11/06 at 177.)

146. None of the State's ophthalmologist witnesses measured their patients' vision other than with a Snellen chart and thus had only the Snellen score to record. (See Ex. 501.)

147. The State's evidence shows that there is no standardized way of recording patients' vision, particularly when a physician measures both his patients' Snellen and contrast

sensitivity vision. Instead, most ophthalmologists have their own way of keeping their charts. (Watson at 183-84; Cleary at 54-55; Cavin at 232; Freeman, 12/18/06 at 130-31; Javitt at 91-92.)

148. The State introduced no evidence that the best corrected visual acuity must be entered beside the preprinted “V” on Dr. Chase’s chart. To the contrary, Dr. Javitt and the State’s own witness, Dr. Tabin, testified that the big “V” does not necessarily designate best corrected Snellen vision, thereby undercutting the State’s claim. (Javitt at 90, 92-93; Tabin at 77.)

149. The 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. (Cavin at 232; Tabin at 76; Freeman, 1/8/07 at 85.)

150. There was nothing improper or misleading in the way Dr. Chase recorded his patients’ CST/BAT scores next to the “V” in his chart. (Freeman, 1/8/07 at 84; Javitt at 92-93.)

151. Most doctors were hard pressed to interpret other physicians’ charts, and some of the State’s physician witnesses’ charts were illegible. (Cavin at 232-34, 237; Watson at 184; Irwin at 184-86.)

152. Unlike Dr. Chase, some of the State’s ophthalmologist witnesses did not even measure, much less record, their patients’ best corrected Snellen visual acuity prior to offering their patients’ cataract surgery. (Cavin at 230.)

153. When sending his medical records to another physician, Dr. Chase always included a summary chart clearly and correctly labeling his patients’ vision scores as Snellen or CST/BAT. (*See, e.g.*, 501-HN-1-017; 501-SLI-1-108; Chase, 9/12/06 at 165-66; 9/21/06 at 133-34; 501-JC-1-015.)

154. When asked, Dr. Chase expressly informed insurance companies in writing exactly how he was charting vision. (Ex. 523; Chase, 9/26/06 at 62-68.) They even surveyed his practice. (Chase, 9/26/06 at 62-68.) No insurance company ever challenged his recordkeeping practices. (Chase, 9/26/06 at 67-68.)

155. There is no evidence that any healthcare provider or insurer was ever confused, either in rendering treatment or paying a claim, by Dr. Chase’s method of recording his patients’ vision. (Chase, 9/11/06 at 177.)

156. As a result, the State’s implicit suggestion that Dr. Chase acted unprofessionally in failing to record his patients’ best corrected visual acuity in a standardized manner that every

other physician would immediately understand without examination is unsupported by the evidence.

C. Dr. Chase's Method Of Describing Cataracts In His Medical Chart

157. When Dr. Chase was learning how to perform phacoemulsification in the 1970s, he was taught to grade cataracts according to their hardness on a scale of 1 to 4. (Chase, 9/11/06 at 120-21; 9/12/06 at 201.) However, he abandoned the 1 through 4 grading scale as his surgical skills improved and because he did not find it useful to attempt to judge the hardness of a cataract by its appearance. (*Id.* at 121-22.)

158. Instead, Dr. Chase found it more helpful to him, and therefore better for his patients' care, if he divided his patients' cataracts into two categories: those that were visually significant and those that were not, and he described visually significant cataracts as "dense" and others simply as cataracts. (Chase, 9/11/06 at 121-24, 193-94; 9/12/06 at 193, 201-02.)

159. The State's own ophthalmologist, Dr. Tabin, testified that there is nothing wrong with categorizing cataracts only as visually significant or visually insignificant. (Tabin at 49.) Dr. Guilfooy testified it was appropriate to use dense to describe visually significant cataracts if it helped the doctor deliver quality care. (Guilfooy at 209; Freeman, 12/18/06 at 143-44.) Indeed, a physician is free to use the rating system that best helps him provide quality care to his patients. (Cavin at 174-75; Cleary at 47; Watson at 134; Tabin at 49.)

160. A physician cannot tell how a cataract will affect a patient's vision simply by assessing its physical appearance. (Cavin at 177; Morhun at 53; Chase, 9/11/06 at 195; 9/12/06 at 86-87; Freeman, 12/18/06 at 100-01, 1/8/07 at 67-68.)

161. A 2006 peer reviewed article appearing in the AAO's premier publication, Ophthalmology, and based on the ongoing, 20 year old Beaver Dam Study, confirmed that early and mild appearing cataracts often cause significant functional vision loss in patients, particularly younger patients. (Freeman, 12/18/06 at 127-28; Ex. 819, Beaver Dam Study.)

162. 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. (Javitt at 81-82.)

163. There exists no requirement that ophthalmologists describe or rate the physical severity of their patients' cataracts; rather they need only determine whether and to what extent

the cataract interferes with the patient's functional vision. (Cavin at 176-77; Freeman, 1/8/07 at 67-68; Morhun at 52; Watson at 137; Tabin at 47-48.)

164. Those ophthalmologists that do rate their cataracts do not all use the same system (Freeman, 12/18/06 at 106-08; Cavin at 176-77; Watson at 131-35; Cleary at 43; Tabin at 47-48; Morhun at 52), and all testifying doctors agreed that all rating scales used to describe cataracts are highly "subjective," "nebulous," and "imprecise." (Cavin at 175; Irwin at 108; Guilfooy at 199.)

165. Dr. Irwin uses a 1-4 grading system to describe cataracts but has used the numerical grades to describe different degrees of opacification at different times. (Irwin at 111-14; Exh. 822.)

166. Some physicians grade their patients' cataracts in order to help guide their surgical technique: more mature cataracts often take more time and carry more risk to remove than do earlier cataracts, (Cavin at 173; Morhun at 17-18, 56), while others grade cataracts in the belief it will help them assess how much the cataract is affecting the patient's vision. (Cleary at 47; Watson at 137-38.)

167. For instance, Dr. Cleary invented her own category of cataract, called "haze," to give herself more information on how her patients' cataracts were affecting their vision. (Cleary at 47.) She also reserved the term "cataract" for those opacities that affect a patient's vision, admittedly contrary to the AAO PPP's definition. (Cleary at 37-41.)

168. Dr. Cavin uses the phrase "quite clear" to designate some cloudiness in the lens that is not significantly affecting the patient's vision. (Cavin at 172-73.)

169. Dr. Watson and Dr. Irwin do not even call a lens opacity a cataract until they feel it is interfering with a patient's vision. (Watson at 137-38, 174; Irwin at 39.)

170. 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. (Irwin at 223-26.)

171. In some instances, the same doctor even described the same cataracts differently on two separate visits. (Tabin at 96-97.)

172. Even good ophthalmologists may sometimes fail to see a cataract, particularly an early cataract. (Tabin at 96-97; Morhun at 49-50.) As a result, sometimes one good ophthalmologist will observe a cataract that another good ophthalmologist will not. (Tabin at 96-97.)

173. 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. (*Compare* Ex. 501-MM-1-003 to 501-MM-2-019 and 2-020.)

174. Dr. Cleary failed to identify nuclear, cortical, and posterior subcapsular cataracts diagnosed in Frank Cole by Dr. Maguire, a retinal specialist who was not even examining him for purposes of evaluating those cataracts. (*Compare* Ex. 501-FC-2-004 to Ex. 501-FC-2-032.)

175. Dr. Irwin diagnosed Judith Salatino with trace cortical cataracts but not other opacities, while a few weeks later Dr. Morhun diagnosed the same patient as having no cortical cataracts but having a 1+ nuclear cataract and a 2+ capsular opacity. (Irwin at 223-26.)

176. Dr. Tabin repeatedly failed to see cortical cataracts that he had personally identified in a patient on prior visits. (*Compare* Ex. 501-SL1-2-004 to Ex. 501-SL1-2-011.)

177. Dr. Irwin diagnosed Jan Kerr with nuclear and cortical cataracts, and one month later Dr. Guilfooy diagnosed her as having no cataracts. (Guilfooy at 235-37.)

178. The Board concludes from the State's evidence that all clinicians' identifications and physical descriptions of cataracts are highly subjective and display wide inter-observer and intra-observer variations.

179. That subjectivity applies not only to the grade and location/type 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." (Irwin at 121.)

180. Many doctors combine physical and functional components when describing their patients' cataracts, 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. (Cavin at 172, 174; Watson at 129-30, 137, 175; Cleary at 37-41, 44.) They then record their description in the physical examination portion of the chart. (*See* Ex. 501.) Dr. Freeman explained that there is more mixing of objective and subjective descriptions in ophthalmology charting than in internal medicine because of the different manner in which ophthalmologists gather and assess information. (Freeman, 12/18/06 at 144-45.)

181. 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." (Cavin at 174.)

182. Dr. Irwin also employs a "functional definition" when describing cataracts, accounting for how the cataract affects vision. (Irwin at 39.) In fact, he will not describe a lens

opacity as a cataract unless it interferes with vision. (Irwin at 39.) He does not use the word dense to describe cataracts, because, to him, its meaning is too imprecise to be useful. (Irwin at 120.)

183. 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. Instead, they always examine and grade the patients' cataracts themselves, using their own systems. (Cavin at 176, 238; Watson at 136-37; Cleary at 59; Morhun at 51; Guilfooy at 201; Freeman, 12/18/06 at 108; Chase, 9/12/06 at 91-92; 9/21/06 at 45, 153; Javitt at 120.)

184. There is no evidence that anyone was misled, or likely to be misled, by Dr. Chase's use of "dense" to designate visually significant cataracts.

185. Dr. Chase did not falsify his description of the complaining patients' cataracts by using the word "dense" to describe visually significant cataracts. Nor did he act unprofessionally by combining functional and physical descriptions of his patients' cataracts.

D. Dr. Chase's Method Of Recording His Patients' Symptoms

186. Dr. Chase's technicians would record his patients' symptoms in the "history" section of his examination notes. (Chase, 9/11/06 at 172-73.)

187. Often, his technicians would paraphrase and summarize the patients' complaints; occasionally they would place quotation marks around a complaint, indicating it was a verbatim quote. (Chase, 9/21/06 at 62, 106, 130.)

188. When Dr. Chase examined his patients, reviewed their test results, and spoke to them about their vision, he would often record his own conclusions regarding the patients' symptoms in the history section of the chart, thereby summarizing all of the diagnostic information available to him. (Chase, 9/11/06 at 175-76; 9/12/06 at 106-09, 111, 113-14, 214.)

189. Dr. Chase's conclusions regarding his patients' symptoms were always supported by the information contained in their charts, including the questionnaires, histories, physical examinations, and vision test scores. (Chase, 9/12/06 at 106-09, 111.)

190. Other ophthalmologists, too, regularly recorded their own conclusions regarding their patients' symptoms in the "history" section of their charts during the latter part of the patient exam. (Freeman, 12/18/06 at 104-05; Irwin at 8-9; Ex. 501-JS-2-001; Cavin at 243-44; Watson at 124-25; Javitt at 118-19.)

191. Dr. Chase therefore did not falsify any of the complaining patients' symptoms.

E. Dr. Chase's Informed Consent Process

192. If Dr. Chase believed that a patient should consider the option of cataract surgery as treatment for their cataract-related visual symptoms, he would always ask the patient, "Are you interested in hearing about cataract surgery?"; if the patient answered "no," he would normally not discuss the topic further. (Chase, 9/25/06 at 90-91; 9/26/06 at 8-9, 59.)

193. If the patient responded "yes," Dr. Chase would summarize the potential risks and possible benefits of cataract surgery. (Chase, 9/25/06 at 84,92-93.)

194. He would also tell each patient "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." (Chase, 9/25/06 at 84; 9/11/06 at 199-200; 9/12/06 at 19-20.)

195. Dr. Chase's hypothetical "second opinion" was one of several ways in which he and his office staff attempted to explain 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. (*Id.*) It was part of his informed consent process. (Chase, 9/12/06 at 19-20, 29; 9/11/06 at 199; 9/25/06 at 84.)

196. Dr. Chase's discussion of second opinions to illustrate the elective nature of cataract surgery was not misleading or improper. (Freeman, 12/18/06 at 152-53; Javitt at 99-101.)

197. Dr. Chase's scribes chose to record this in his charts with the shorthand phrase "second opinion given;" Dr. Chase did not instruct his scribes to use this shorthand description, (Chase, 9/12/06 at 20, 21, 129; 9/11/06 at 199; 9/25/06 at 122-23), but neither did he disapprove of this notation because as he reviewed his charts, it allowed him to determine whether he had provided his patients with his normal informed consent presentation. (Chase, 9/12/06 at 21-22.)

198. Dr. Chase *never* told his patients that if they sought a second opinion, other doctors would agree with his advice or tell the patients that surgery was warranted. (Chase, 9/25/06 at 8.)

199. Dr. Cavin used a similar speech with his patients, telling them that a second opinion doctor may well agree with his assessment, but if he did not, both he and the patient might learn something. (Cavin at 216.)

200. 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. (Javitt at 100-01.)

201. Dr. Chase then directed the patient to a registered nurse, who he employed to provide a much more extensive informed consent presentation to the patients, and to schedule them for surgery if they chose this option after learning more about the procedure. (Salatino at 54-55.)

202. Although there were no legal requirements that the practice employ an R.N. to counsel cataract surgery candidates, Dr. Chase preferred to have someone with “the resources,” “the expertise,” and the “knowledge base” of an RN in that role. (Ellen Flanagan Federal Trial Testimony at 12¹; Chase, 9/12/06 at 155-56.)

* 203. Although Dr. Chase was ultimately responsible for making certain that the informed consent process was complete, the nurse understood that “quite often people are overstimulated when they are looking at a surgical experience and things go right over their head when they are sitting and talking with a doctor.” (Flanagan Federal Trial Testimony at 23.)

204. As a result, the nurses spent between 1.25 and 1.5 hours with each patient, helping them understand their treatment choices and the consequences of those choices. (*Id.* at 32; Chase, 9/12/06 at 32-33.)

205. The State’s testifying ophthalmologists spent five to fifteen minutes delivering their informed consent presentation. (Cavin at 227 (“five minutes”); Morhun at 133 (“five to ten minutes”); Irwin at 152-51 (“ten to 15 minutes”).)

* 206. The nurse told each patient that cataract surgery was elective. (Flanagan Federal Trial Testimony at 43-44.) She told them that there was “no urgency” to have the surgery. (*Id.* at 43.) The decision to have surgery, she said, “depends [on whether] they were having trouble driving or if they were really having [other] symptoms.” (*Id.* at 44.)

¹ Ellen Flanagan’s testimony was proffered to the Board, but excluded as “cumulative” because the Board was satisfied that Dr. Chase’s informed consent process was comprehensive. Her proffered testimony is cited herein to provide factual support for the Board’s anticipated findings. All proposed findings that rely solely upon Ms. Flanagan’s prior trial testimony are designated with an asterisk (“*”).

*207. The nurse informed all patients that there were certain advantages to their own natural lenses, (*Id.* at 38), and that each patient had to individually weigh the potential of seeing better against the benefits of maintaining those natural lenses. (*Id.*) She discussed the alternatives to cataract surgery with each patient, including the potential benefits, if any, of simply getting new glasses. (*Id.* at 38-39.)

208. As part of her teaching, the nurse reviewed Dr. Chase's informed consent form with each patient, all the while emphasizing that it was the patient's choice to proceed with surgery or not and that Dr. Chase would respect the patient's decision. (*Id.* at 41; Chase 9/21/06 at 29-31.)

209. 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.

(*See, e.g.,* Ex. 501-JS-1-029 (emphasis added).)

210. Dr. Chase's informed consent document is far more comprehensive than the generic forms used by all ophthalmologists who perform surgery at Fletcher Allen. (*See* Ex. 820; Cavin at 223-25; Irwin at 142-43.)

211. 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. (Chase, 9/21/06 at 31-32; Irwin at 143.) Instead, he asked every patient to take the document home, review it, discuss it with family, and call with any follow-up questions. (Chase, 9/21/06 at 31-32; Salatino at 58.) The patients were only required to sign the informed consent document on the day of surgery, after all of their questions were addressed. (Chase, 9/21/06 at 31-32; Salatino at 58.)

212. 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. Marilyn Grigas produced the pamphlet that Dr. Chase's nurse had given to her. 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.*" (Ex. 616 at 13 (emphasis added).)

*213. If patients were reluctant to go forward with surgery, the nurse would be "very respectful of their reservations," saying, "I want you to feel comfortable with this. I want you to feel safe about this." (Flanagan Federal Trial Testimony at 50.)

*214. 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." (*Id.* at 52.)

215. The informed consent process provided patients with the information they needed to make an intelligent decision regarding surgery. (Lang at 66, 68; McGowan at 154-58; Salatino at 58-63.)

*216. As part of her preoperative counseling, the nurse also taught each patient about the anatomy of the eye and its natural lens, using a large-scale model. (Flanagan Federal Trial Testimony at 35-36.) She showed patients an IOL like the one that would be placed in their eyes during surgery, explaining to them exactly what they should expect from the surgical experience if they decided to go forward. (*Id.* at 36-37.)

*217. The nurse took extra care explaining the choice of cataract surgery because she understood that Dr. Chase was not always the best communicator. "He tended to talk softly and quickly, and I think people . . . contemplating surgery are so overstimulated that [they] do not always hear everything that's told to [them] anyway, so I found that they'd pick up on some things but not on all things." (Flanagan Federal Trial Testimony at 58.)

218. All of Dr. Chase's nurses were true "patient advocates" and Dr. Chase intended them to act as such. (Chase, 9/12/06 at 154; Grigas at 173.)

219. The nurse attempted to supplement Dr. Chase's manner of communicating and relating to the patient:

[K]nowing that maybe people hadn't heard everything, or felt that their concerns weren't taken into consideration, I would try to make up for that shortfall, you know, and I would ask people, How are you doing? How are you feeling about this? *Because I saw my role as helping people be informed about this procedure, but to feel safe like it was the right thing for them. I wanted them to*

feel like, that we – that we in general, and I in particular, cared about them as an entire person, not just as a cataract case. It was important to me that they – that they felt safe, that they felt cared for and that they felt like they could come to us with questions to their full satisfaction.

(Flanagan Federal Trial Testimony at 59-60.)

220. A significant percentage of the patients to whom Dr. Chase offered cataract surgery decided after the informed consent process that they were not yet ready for surgery. (Chase, 9/12/06 at 46, 154; 9/25/06 at 91-92.)

221. Dr. Chase considered the nurse's informed consent presentation to be an integral part of the overall examination. (Chase, 9/12/06 at 154.) It is reasonable, indeed advantageous, for a doctor to delegate this portion of the exam to a nurse, because sometimes patients respond better to a nurse than a physician. (Freeman, 1/8/07 at 80-81; Javitt at 50-51.)

222. Dr. Chase's practice of utilizing a registered nurse to administer his informed consent process was an extraordinarily good one. Having a registered nurse, rather than the doctor, to deliver the informed consent presentation allows the patient to weigh the risks and benefits of cataract surgery outside of the doctor's presence and influence. (Javitt at 51.)

223. Based on all of this evidence, the Board concludes that Dr. Chase did not discourage his patients from seeking a second opinion.

224. Based on all of this evidence, the Board concludes that Dr. Chase did not falsify his patients' charts which his scribes recorded "second opinion given."

IX. THE COMPLAINING PATIENTS

225. The State is pressing its charges based upon 11 complaining patients, involving 11 examinations (one for each patient) occurring over eleven years between 1992 and 2003.

226. During that same period, Dr. Chase performed between 2,500 and 3,000 cataract surgeries and had over 80,000 patients visits.

227. Only one of those complaining patients, Helena Nordstrom, filed a complaint with the Board prior to the summary suspension of Dr. Chase's medical license and the accompanying publicity.

228. The remaining 10 complaining patients filed their complaints with the Board only after reading newspaper reports or seeing television accounts of Dr. Chase's summary suspension; those media reports suggested that the Board had accepted the State's allegations

that Dr. Chase had engaged in a pattern of recommending and performing unnecessary cataract surgery.

229. The three out of the 11 complaining patients who actually had surgery are participating in lawsuits seeking money damages against Dr. Chase, all of which were commenced after his summary suspension and the resulting publicity, and notwithstanding their positive surgical outcomes. (Lang at 26; Salatino at 78-79; McGowan at 117, 120-21.)

230. In 2004 and again in 2006, Dr. Chase asked each of the 11 patients to consent to an eye examination by his own ophthalmologist expert witness; the Board declined to require such examinations; the State refused to encourage the patients to consent to such examinations; and every patient refused to undergo such an examination. (Freeman, 1/8/07 at 111.)

231. As discussed below, Dr. Chase acted consistently with the AAO PPP in offering 10 of the 11 complaining witnesses cataract surgery because:² (1) they all had cataracts; (2) they all had visual symptoms caused by their cataracts that could not be corrected with glasses; (3) their symptoms were confirmed by CST and BAT.

A. All Of The Complaining Patients Had Cataracts

232. With the exception of Ms. Nordstrom, who is discussed separately below, the State's witnesses and the Respondent agree that all of the complaining patients had cataracts when examined by Dr. Chase and by the State's physician witnesses. (AAO PPP at 3; Cavin at 240, 250; Guilfooy at 248; Watson at 188; Cleary at 84; Irwin at 170, 191, 221-22; Tabin at 29-30; Morhun at 21, 25; *see also* ¶ 266 through ¶ 617 below.)

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

233. Each of the 11 patients admitted that he or she was experiencing symptoms of visual impairment at the time of Dr. Chase's surgery recommendations. (*See* ¶ 26 through ¶ 617 below.)

234. In some instances, the patients' complaints were recorded by Dr. Chase's technician at the outset of the examination. (*Id.*)

235. In others, the patients themselves recorded their symptoms on patient questionnaires. (*Id.*)

236. In still others, Dr. Chase recorded additional patient symptoms after examining and speaking with the patients. (*Id.*)

² As discussed below, Dr. Olson was not offered cataract surgery by Dr. Chase.

237. Moreover, in each case, the patients *admitted under oath* that they were suffering visual symptoms at the time they saw Dr. Chase. (*Id.*)

C. The Patients' Complaints Were Corroborated By CST/BAT

238. Dr. Chase tested all of the complaining patients' vision using CST and glare. (*See* ¶ 266 through ¶ 617 below.)

239. Dr. Chase used the Mentor Brightness Acuity Tester ("BAT") to simulate glare, a standardized, reproducible glare source designed to be used as such. (Ex. 615, BAT; Ginsburg at 86.)

240. When Dr. Chase's technicians tested the complaining patients using the CST and BAT, each patient demonstrated a significant functional visual deficit. (Evans at 208-09.)

241. Dr. Chase did not recommend surgery to any of the complaining patients unless, among other things, they scored at patch 3 or below on the 6 c/d row of the VectorVision CST test with the BAT on its highest setting. (*See* ¶ 266 through ¶ 617 below; Ginsburg at 77.)

242. Patch 3 is below the normal contrast sensitivity range for all age groups, and well below the normal range for the complaining patients. A patient score of patch 3 with BAT on high demonstrates a loss of about 25% in night driving target recognition, a deficit that the FDA classifies as a safety problem. (Ginsburg at 77, 80, 84.)

243. As a result, if a patient scored patch 3 or below on the 6 c/d row of the VectorVision CST with the BAT on its highest setting, Dr. Chase was justified in concluding that the patient was unsafe to drive at night. (Ginsburg at 80.)

244. Dr. Chase's use of patch 3 as a threshold above which he would not perform cataract surgery was a conservative threshold for judging the functional significance of his patients' contrast sensitivity deficits. (Ginsburg at 84-85.)

245. None of the State's physician witnesses evaluated the patients' contrast sensitivity; as a result, the State has not demonstrated, and cannot demonstrate, that Dr. Chase was incorrect in concluding that his patients' cataracts were functionally visually significant and warranted cataract surgery if the patients decided to have it.

D. Doctor Chase Reasonably Attributed The Patients' Symptoms To Their Cataracts

246. As to all 11 patients, based on his entire examination and his 35 years of experience, Dr. Chase ruled out other possible causes of their visual symptoms, including

uncorrected refractive error – such as nearsightedness, farsightedness, and astigmatism – and reasonably attributed their visual problems to their cataracts. (*See* ¶ 266 through ¶ 617 below.)

247. None of the State’s doctors identified any non-cataract cause of the patients’ visual symptoms in their hearing testimony. (*Id.*)

248. Dr. James Freeman examined the charts of both Dr. Chase and the second opinion doctors, and concluded that no ophthalmologist identified a cause for the patients’ symptoms other than their cataracts—except for Dr. Morhun’s admittedly mistaken initial conclusion that Ms. Nordstrom simply needed a new pair of glasses. (Freeman, 1/8/07 at 87.)

249. Dr. Chase therefore acted reasonably in concluding that the patients’ symptoms were caused by their cataracts, and that he could expect to improve their symptoms through cataract surgery.

E. The State Has Introduced No Evidence That Any Patient’s Symptoms Could Be Corrected With New Glasses

250. The State 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. (*See* ¶ 266 through ¶ 617 below.)

251. All of the available evidence shows that new glasses would not have alleviated the patients’ symptoms. New spectacles prescriptions are most effective in addressing the change caused by cataract in the refractive index of the lens. Even refractive index changes are not susceptible to effective correction with spectacles when index changes occur frequently.

252. Normally, problems with glare, which were experienced by eight of the patients, cannot be corrected with new glasses. Similarly, losses in contrast sensitivity, which were experienced by all 11 patients, which includes difficulty seeing in dim light, cannot be resolved without removing the opacity in the lens that is causing it. (Javitt at 79.)

253. Nonetheless, Dr. Chase and his staff refracted each of the 11 complaining patients three times, and found that the patient would experience no significant improvement in his or her vision with a new glasses prescription. (*See* ¶ 266 through ¶ 617 below.)

254. It is undisputed that all of Dr. Chase’s CST and BAT was performed after the patients were refracted and given their best possible correction. (Chase, 9/11/06 at 140-41.) Thus, the significant contrast sensitivity and glare deficits were detected by testing the complaining patients’ corrected vision that could not be further improved with glasses.

255. None of the State’s physician witnesses attempted to improve the patients’ glare vision or contrast sensitivity with new glasses, and therefore did not offer any evidence that was contrary to Dr. Chase’s conclusions.

**F. Dr. Chase Acted Within The Standard Of Care In Offering His Patients
Cataract Surgery And Providing Them The Information They Needed
To Make Their Own Decision Regarding Surgery**

256. Because all of the eleven patients had cataracts and complained of cataract related symptoms that could not be remedied through glasses, Dr. Chase acted consistently with the AAO PPP in offering them cataract surgery and providing them the information they needed to decide for or against surgery, depending on their own assessment of their visual needs and symptoms.

257. The State introduced no evidence that Dr. Chase coerced his patients into having cataract surgery that they did not want; to the contrary, all of the eleven patients exercised their own informed choice regarding cataract surgery, and eight of the eleven patients chose not to have surgery.

258. 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, (Cavin at 231; Irwin at 260-61), and a patient’s decision against elective surgery does not render the physician’s recommendation unprofessional. (Watson at 177-78; Cavin at 231; Irwin at 260-61; Morhun.)

259. In fact, a patient cannot intelligently choose to have surgery, or not, until the ophthalmologist offers it and describes the risks and benefits. (Cavin at 209-10; Watson at 170; Cleary at 53.)

260. Three of the 11 patients decided to proceed with cataract surgery on one eye—Judith Salatino, Margaret McGowan, and Susan Lang.

261. All three surgical patients testified that the informed consent process provided them with the information they needed to make an intelligent decision regarding surgery. (Lang at 66, 68; McGowan at 154-58; Salatino at 58-63.)

262. These facts demonstrate that all three of Dr. Chase’s surgical patients determined that they had “vision that no longer [met] their needs,” as required by the American Academy of Ophthalmology.

263. Because not a single doctor has testified that Dr. Chase did not conform to professional standards in operating, on these patients, the State has not demonstrated that these patients received unnecessary cataract surgery.

264. Similarly, Dr. Chase's decision to offer cataract surgery to Ms. Nordstrom, Ms. Grigas, Ms. Corning, Mr. Cole, Mr. Touchette, Mr. Augood Pierson, and Ms. Kerr conformed to professional standards.

265. The fact that they decided against surgery confirms the effectiveness of Dr. Chase's informal consent procedures.

1. Dr. Chase Acted Professionally As To Helena Nordstrom (Patient #1)

266. Helena Nordstrom testified at the merits hearing on October 23, 2006. She is 47 years old and performs office work. (Nordstrom at 4.)

267. Ms. Nordstrom saw Dr. Chase on only one occasion: January 17, 2003. She went to see Dr. Chase because the vision in her left eye had become constantly blurry in the preceding two or three weeks. (Nordstrom at 18-19; Ex. 501-HN-1-001.)

268. Ms. Nordstrom testified she thought she needed a new glasses prescription, as she had in the past. (Nordstrom at 18-19.) Her regular eye doctor, an optometrist, could not fit her into his schedule for many weeks. Her boyfriend knew Dr. Chase, and Dr. Chase agreed to see her immediately. (*Id.*)

269. Ms. Nordstrom's visual impairments caused her more difficulty reading road signs and driving at night. She was also experiencing headaches and nausea that she attributed to her eyestrain. (Nordstrom at 21, 46-47.)

270. The technician who took Ms. Nordstrom's history recorded that Ms. Nordstrom also reported darker vision in her left eye than in her right, and Ms. Nordstrom admitted that she may have reported symptoms to that effect. (Ex. 501-HN-1-001; Nordstrom at 47.)

271. When she viewed the Snellen chart in Dr. Chase's office after being refracted and with her best corrected vision, she performed poorly, both as measured by the autorefractor, the technician, and by Dr. Chase himself. (Nordstrom at 50; Ex. 501-HN-1-012, 013.)

272. Ms. Nordstrom testified that when her Snellen vision was tested prior to dilation, the Snellen chart appeared blurry. (Nordstrom at 50, 91.)

273. 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. (Ex. 501-HN-1-001; Chase, 9/12/06 at 161-64; Freeman, 1/8/07 at 39-40.)

274. Dr. Chase diagnosed Ms. Nordstrom with cataracts; he performed his physical examination of Ms. Nordstrom's lenses through both a slit lamp and a direct ophthalmoscope, which provides retroillumination and enables the physician to better detect disturbances in the lens cortex, while her eyes were fully dilated. (Chase, 9/11/06 at 162; 9/12/06 at 41-42.)

275. Dr. Chase's technicians performed CST/BAT testing on Ms. Nordstrom prior to dilating her eyes; (Nordstrom at 51), that testing showed that she was experiencing a significant contrast sensitivity deficit. (Ex. 501-HN-1-013.) Her contrast sensitivity was 40% below the bottom of the normal range for her age and 85% below the average. (Evans at 208-09.)

276. Dr. Chase and his staff performed an extensive examination of Ms. Nordstrom in order to rule out any other causes of her visual symptoms, performing three refractions, automated visual fields, and even an Amsler grid test to rule out macular problems. (Ex. 501-HN-1-002; Chase, 9/12/06 at 136-39; Freeman, 1/8/07 at 40-41.)

277. Based on the entirety of his examination, Dr. Chase determined that Ms. Nordstrom was suffering from cataracts, which were causing her vision problems; he found no other ocular condition that might account for her symptoms, which could not be improved through a new glasses prescription. (Ex. 501-HN-1-002; Chase, 9/12/06 at 135-136; Freeman, 1/8/07 at 40-42.)

278. Dr. Chase described her cataracts as being a "circular opacity in the central cortex and nucleus." (Chase, 9/11/06 at 196.)

279. On this basis, Dr. Chase recommended that she receive cataract surgery if she wanted to remedy her symptoms, and referred Ms. Nordstrom to his counseling nurse to receive preoperative teaching and the informed consent regarding cataract surgery. (Chase, 9/12/06 at 29-30.)

280. However, prior to performing cataract surgery on Ms. Nordstrom, Dr. Chase ordered her to get a 2-hour blood sugar and CBC test. (Ex. 501-HN-1-002; Ex. 705; Ex. 818, Chase, 9/12/06 at 153-55.) Ms. Nordstrom understood that she was to get the blood test prior to undergoing surgery and that the scheduled surgery was contingent upon the results. (Nordstrom at 66-68.)

281. 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 (“water clefts” or “vacuoles”) that disappear as sugar levels stabilize. (Chase, 9/12/06 at 153-55.) If Ms. Nordstrom would have asked to move forward with surgery without getting the blood test, Dr. Chase would have refused to perform the surgery. (Chase, 9/12/06 at 153.)

282. Dr. Morhun and Dr. Tabin acknowledged that the 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. (Tabin at 46; Morhun at 46.)

283. Dr. Morhun also testified that it is reasonable for a doctor who fears that a patient’s cataracts may be transitory to order the necessary blood tests and hold a spot on the surgical schedule pending the outcome of the blood tests. (Morhun at 265-66.) It was reasonable for Dr. Chase to recommend cataract surgery to Ms. Nordstrom pending the blood sugar test. (Freeman, 1/8/07 at 42.)

284. The State’s ophthalmologists and Dr. Chase’s expert witnesses all agree that fluctuating blood sugar levels and/or diabetes can cause transitory cataracts. (Cavin at 165; Tabin at 44-46; Morhun at 42-44; Freeman at , 12/18/06 at 108-10; 1/8/07 at 42-43.)

285. Water clefts look like normal cataracts upon physical examination and cause the same symptoms as normal cataracts, including blurry vision and reduced contrast sensitivity. (Morhun at 43.)

286. Ophthalmologists often misdiagnose water clefts as uncorrected refractive error. (Javitt at 53.)

287. Water clefts may also cause fluctuating vision, such as the blurry vision that Ms. Nordstrom had reported experiencing for two to three weeks prior to seeing Dr. Chase. (Freeman, 12/18/06 at 109-10; 1/8/07 at 43.)

288. In recommending surgery to Ms. Nordstrom, Dr. Chase told her, as he did all his potential cataract surgery patients: “[I]f you go to any other eye doctor and say I’ve come for a second opinion, Dr. Chase says I’ve got cataracts and they need to come out, you will most likely be told that if you see well enough to suit you, its not going to damage your eyes not to have cataract surgery.” (Chase, 9/11/06 at 200.)

289. Ms. Nordstrom went to see the nurse, scheduled an informed consent meeting for the following week, and reserved a spot on the surgical schedule one week after that. The nurse

was kind and informative. (Nordstrom at 56, 62-63.) No one pressured Ms. Nordstrom into scheduling her cataract surgery. (Nordstrom at 56-62.)

290. Ms Nordstrom declined to get the blood sugar test Dr. Chase had ordered and did not go forward with surgery. She testified that her distance vision nonetheless improved over the coming months—a fact that she erroneously attributed to new glasses given to her by her optometrist. (Nordstrom at 91.)

291. Because Ms. Nordstrom believed that she had been recommended cataract surgery that she did not need, she filed a complaint with the Board; the Board arranged for her to be examined by New Hampshire ophthalmologist Dr. Patrick Morhun, who was asked to examine Ms. Nordstrom during his interview for admission to practice in Vermont. (Morhun at 255.)

292. The Board’s investigator, Phil Ciotti, scheduled Ms. Nordstrom to be examined by Dr. Morhun on June 30, 2003. Ms. Nordstrom has testified under oath on at least three separate occasions that Mr. Ciotti instructed her not to tell Dr. Morhun about her prior symptoms, her experience with Dr. Chase, or the fact that he had ordered a blood sugar test. (Nordstrom 80-87.)

293. At the outset of his examination, Dr. Morhun asked Ms. Nordstrom if she was experiencing any visual symptoms, or whether she had experienced any visual symptoms in the past. In fact, because he sees most of his cataract patients only once before performing surgery on them, Dr. Morhun “absolutely” always asks his patients if they have experienced any visual symptoms in the past. Past symptoms are very important to his diagnosis of cataract patients, and he expects and relies upon patients to truthfully report past symptoms. (Morhun at 35-37.) Dr. Morhun testified that, if he is to make an accurate diagnosis of a patient, it is important for him to know if that patient experienced any past visual symptoms. (Morhun at 46.)

294. When asked by Dr. Morhun, Ms. Nordstrom denied experiencing any visual symptoms in the past. (Morhun at 14-15, 147.) Ms. Nordstrom’s denial of any past symptoms to Dr. Morhun was untrue.

295. If Ms. Nordstrom had been experiencing past symptoms, that fact would have been important to Dr. Morhun’s assessment of her vision. (Morhun at 148.) Dr. Morhun agreed that if Ms. Nordstrom had been experiencing blurry vision, dim vision, and has having trouble reading, “that would have changed everything.” (Morhun at 149-150.)

296. Unlike Dr. Chase's examination, Dr. Morhun's examination of Ms. Nordstrom did not include automated visual fields, CST/BAT testing, or Amsler grid testing. (Ex. 501-HN-2-000-004.)

297. Dr. Morhun did not examine Ms. Nordstrom's lens (or any of his patients' lenses) using retroillumination from a direct ophthalmoscope; rather, he used only his slit lamp to examine her lens. (Morhun at 152.)

298. Dr. Morhun did not perform glare testing or contrast sensitivity testing on Ms. Nordstrom. (Ex. 501-HN-2-000-004.)

299. Dr. Morhun noticed no cataract when he examined Ms. Nordstrom in June 2003. (Morhun at 16, 174.)

300. By that time, Ms. Nordstrom's Snellen vision had greatly improved; Dr. Morhun's examination confirmed, however, that her vision did not improve due to new glasses because her prescription was virtually unchanged as compared either to the glasses she wore into Dr. Chase's office or Dr. Chase's refraction. (Morhun at 158; Chase, 9/12/06 at 170; Freeman, 1/8/07 at 46-47.)

301. Indeed, based on his examination, Dr. Morhun could not find any reason for Ms. Nordstrom's radically improved vision. (Morhun at 158-64.)

302. Dr. Morhun admitted that when a patient's blurry vision has resolved, but there has been no change in her glasses prescription, a good ophthalmologist will consider fluctuating blood sugar as a potential cause of the patient's problems. (Morhun at 46-47.) Although Ms. Nordstrom's glasses had not changed and her symptoms of blurry distance vision had gone away, Dr. Morhun did not order a blood sugar test for Ms. Nordstrom.

303. Despite the knowledge and testimony of its main expert witness, the State continued to suggest at the hearing that Ms. Nordstrom's vision improved because she received new glasses, even though the State knew or should have known that this was untrue. (9/12/06 Questioning by State of Dr. Chase at 37.)

304. Although the State bears the burden of proof, it has offered no explanation for Ms. Nordstrom's admittedly poor vision in January 2003. Dr. Morhun admits that he has none. (Morhun at 161-64; Freeman, 1/8/07 at 53.)

305. Unfortunately, Ms. Nordstrom refused to consent to an independent eye exam by Dr. Chase's expert in order to clarify the possible causes of the vision problems she was experiencing in January 2003. (Freeman, 1/8/07 at 111.)

306. However, the State's own 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.

307. Dr. Morhun admitted that, knowing what he knows now, he can no longer rule out the possibility that Ms. Nordstrom's cataract was transient. (Morhun at 213.)

308. Second, there is a strong possibility that Dr. Morhun simply failed to see Ms. Nordstrom's early oil droplet cataracts, which were intermittently interfering with her vision, particularly in light of the fact that Ms. Nordstrom falsified her visual symptoms to Dr. Morhun and he failed to use retroillumination to examine her lenses and failed to perform many of the other vision tests administered by Dr. Chase's staff. (Freeman, 1/8/07 at 49-56.)

309. 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, (Ex. 501-MM-2-020), but Dr. Morhun failed to see it, (Ex. 501-MM-2-003); Dr. Irwin diagnosed Ms. McGowan as having a cortical cataract, (Ex. 501-MM-2-019), but Dr. Morhun failed to see it, (Ex. 501-MM-2-003); Dr. Irwin diagnosed Ms. Salatino as having a cortical cataract, (Ex. 501-JS-2-002), but Dr. Morhun failed to see it. (Ex. 501-JS-2-011.)

310. It 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 faxed incomplete records that were obviously missing the bottom one-quarter of each page due to Investigator Ciotti's faxing error, whether intentional or not. (Morhun at 185-206.)

311. 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.

312. The Panel also finds that Dr. Morhun has demonstrated an unwillingness to admit to making mistakes: 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. 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 (there was virtually no change in her glasses prescription). (Morhun at 185-206.) Dr. Morhun went so far to say that if he had been given complete information, he would not render the same opinion regarding Dr. Chase. (Morhun at 210.) 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. (Morhun at 208-10; 215-16 ("I think the --- circumstances around the suspension of his license with the faxing irregularities and the errors in interpreting his chart did not give him a fair shake.").)

313. In failing to bring his material mistake to the Board's attention, Dr. Morhun demonstrated a lack of candor toward the Board that is inconsistent with his obligations as a physician licensed to practice in Vermont.

314. The State's and Dr. Morhun's lack of candor and unwillingness to admit to his prior mistakes further undermine the State's unsuccessful attempt to demonstrate that Ms. Nordstrom did not have cataracts.

315. Due to 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.

316. To the contrary, although it is not his obligation to do so, Dr. Chase has proven by a preponderance of the evidence that Ms. Nordstrom did have visually significant cataracts when he examined her.

317. 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." (Nordstrom at 31.)

318. Ms. Nordstrom demonstrated significant unreliability as a witness, admitting on many occasions that she had previously testified untruthfully 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 in drawers everywhere in the office. (Nordstrom at 25-26, 40-44.) In fact, all of the eye drops were in a locked cabinet and were unavailable to patients without Dr. Chase's permission. (B. Chase at 169-70; Ex. 535-U.)

319. Ms. Nordstrom demonstrated a faulty memory of many details of Dr. Chase's treatment of 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 in his office. (B. Chase at 165, 176-77; Ex. 535-I, O-T, W-X.)

320. Neither the Board's investigator nor the Attorney General's office even bothered to speak with Ms. Nordstrom about her visual complaints prior to seeking the summary suspension of Dr. Chase's license on the basis thereof. (Nordstrom at 97.)

321. Ms. Nordstrom also contradicted herself and her prior given testimony in describing why she 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. (Nordstrom at 21-23, 31-34)

322. The State failed to bring to the Board's attention that, in August 2004, Dr. Morhun recanted much of the expert report on which Dr. Chase's summary suspension was based. The State failed to bring to the Board's attention that Dr. Morhun's opinion was based on a materially incomplete set of medical records. The State failed to bring to the Board's attention that Dr. Morhun's opinion was based on Ms. Nordstrom's false report that she had experienced no past visual symptoms. The State failed to bring to the Board's attention Dr. Morhun's statement, made in August 2004, that a truthful report of symptoms "would have changed everything." (Morhun at 149-150.) The State then attempted to prevent the Respondent from bringing these facts to the Board's attention during the merits hearing, objecting to them as irrelevant. (State's Objection, 12/4/2006 at 183-84.) The State has failed to abide by its duty of candor, a duty it owes to this Board, to Dr. Chase, and to the public it purports to represent.

323. The State has alleged that Dr. Chase purposefully discouraged Ms. Nordstrom from obtaining a second opinion regarding cataract surgery. Dr. Chase told Ms. Nordstrom, as he told all of his potential surgery patients: “[If] you go to any other medical eye doctor in the area and say I’ve come for a second opinion, Dr. Chase says I have cataracts and I need cataract surgery, and the doctor will tell you that if you see well enough to suit you, its not going to damage your eyes not to have cataract surgery.” (Chase, 9/21/06 at 121-22.)

324. In giving this presentation to Ms. Nordstrom, Dr. Chase was not intending to discourage her from getting a second opinion; rather, he was attempting to reinforce the fact that cataract surgery is an elective procedure, cataracts do not need to be taken out, and that the patient’s “vision is the determining factor.” (Chase, 9/21/06 at 122.)

325. Although Ms. Nordstrom may have misunderstood the import of Dr. Chase’s presentation, and it perhaps could have been more artfully delivered, Dr. Chase’s statement to Ms. Nordstrom was not improper, and did not discourage her from receiving a second opinion.

2. Dr. Chase Acted Professionally As To Judith Salatino (Patient #2)

326. Judith Salatino testified on October 26, 2006. By 2003, Dr. Chase had treated Judith Salatino, her children and her husband for over 35 years. He had always provided good care to Ms. Salatino and her family, and Ms. Salatino said she had an extremely high degree of loyalty to and trust in Dr. Chase. (Salatino at 5, 18-19, 67-65.)

327. Dr. Chase first diagnosed Ms. Salatino with bilateral cataracts during a January 26, 1994 examination when she was 54 years old. He informed Ms. Salatino that because those cataracts were not interfering with her vision, the proper response was simply to monitor them to ensure any effect on her vision that did develop would be detected. (Ex. 501-JS-1-006, Salatino at 20-21.)

328. Ms. Salatino had another examination by Dr. Chase on August 10, 1995, at which she complained that lights were bothering her more when she drove at night. Dr. Chase again noted the presence of bilateral cataracts and again decided to address them only through continued monitoring. (Ex. 501-JS-1-007.)

329. Dr. Chase examined Ms. Salatino again on September 28, 1998, and during that visit Ms. Salatino complained that she was having more difficulty reading signs and license plates and that it was harder for her to see at night due to glare. No surgery was discussed and, instead, Dr. Chase continued to monitor her cataracts. (Ex. 501-JS-1-009; Salatino at 26-28.)

330. On June 8, 2000, Ms. Salatino reported to Dr. Chase's technician during an examination that she was experiencing blurriness in both eyes and she indicated on an Eye Health History form that she was "bothered by glare." (Ex. 501-JS-1-011, 021; Salatino at 29-30.) In addition to noting the presence of bilateral cataracts, Dr. Chase identified Ms. Salatino as a glaucoma suspect and took photographs of her optic nerve to assist him in detecting any onset of glaucoma. (Ex. 501-JS-1-012, 056.)

331. Although Ms. Salatino has subsequently developed glaucoma, she has no recollection of Dr. Chase telling her she was a glaucoma suspect or of taking photographs of the optic nerve, (Salatino at 31-32, 34), even though the photographs are in her medical chart, (Salatino at 32-34; Ex. 501-JS-1-056), and Dr. Chase's office sent her reminder notices on December 1, 2000 and June 1, 2001 to have her glaucoma checked. (Ex. 501-JS-1-012; Salatino at 34.) At her last comprehensive eye examination on June 11, 2003, the records indicate that a primary reason for the examination was to ensure Ms. Salatino had not developed glaucoma. (Ex. 501-JS-1-013.)

332. At her June 11, 2003 examination, Ms. Salatino stated on her Eye Health History form that she was bothered by glare and floaters. (Ex. 501-JS-1-019.) On a Lifestyle Questionnaire that she completed and signed she stated that her vision sometimes made it a problem for her to read small print, see traffic signs and see steps. She also said 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. (Ex. 501-JS-1-047.)

333. Ms. Salatino's contrast sensitivity with glare test revealed that she saw significantly below average (patch 1 in both eyes, which has a Snellen equivalency score of 20/100). On the same CST test slip, located on the inside left jacket cover, was noted her Snellen test score of 20/30 and 20/25. (Ex. 501-JS-1-064). The 20/100 contrast sensitivity test result is also set forth twice on the first page of the June 11, 2003 exam sheet adjacent to each other, and the second notation of the score is labeled "CST w/BAT, no significant improvement with glasses." (Ex. 501-JS 1-013.) Her contrast sensitivity was 69% below the bottom of the normal range for her age. (Evans at 217.)

334. After reviewing Ms. Salatino's history, objective test scores, subjective vision complaints and his observations during his dilated slit lamp exam, Dr. Chase concluded that Ms.

Salatino was unable to see clearly to drive in glare at night and he noted that on her medical record. (Ex. 501-JS-1-013).

335. 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. (Salatino at 36-37.) Her cataracts were the only cause of her visual symptoms and it was reasonable for Dr. Chase to offer cataract surgery to Ms. Salatino. (Freeman, 12/18/06 at 192-93.)

336. Dr. Chase spoke to Ms. Salatino for approximately 10 to 15 minutes explaining the risks and benefits of cataract surgery. (Salatino at 51-52.) Dr. Chase had performed very successful cataract surgery on Ms. Salatino's husband in 2001 that had a very positive effect on his life. Ms. Salatino had participated in her husband's informed consent procedure and thus had pre-existing familiarity with the nature, risks and benefits of cataract surgery. (Salatino at 53-56.)

337. After speaking to Dr. Chase, Ms. Salatino went through the informed consent procedure with Dr. Chase's nurse and her husband present. The nurse was very clear and thorough in explaining the risks of the surgery and the decision making involved. (Salatino at 54-55.) She made it very clear that Ms. Salatino or her husband should feel free to ask any questions they had. Ms. Salatino was given pamphlets, the informed consent form, and other written material to take home and read, which she did, and she was aware she could call the nurse or Dr. Chase with any questions and that she did not have to make a decision until the day of the surgery. (Salatino 56-57.)

338. Ms. Salatino understood from the informed consent form, (Ex. 501-JS-1-029), 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. (Salatino at 58-62).

339. Dr. Chase informed Ms. Salatino that he could schedule her for surgery within a week or two, but Ms. Salatino said she wanted to wait until after an up-coming vacation and therefore scheduled her cataract surgery for July 15, 2003. (Salatino at 14, 58.)

340. During the five weeks between June 11 and July 15, 2003, Ms. Salatino 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 have the cataract surgery on July 15, 2003. (Salatino at 62-63.)

341. On July 15th she signed the informed consent form in Dr. Chase's office and had cataract surgery performed on her right eye. (Ex. 501-JS-1-029-031.) A few days later she completed a patient survey form, (Ex. 719), in which she stated that the surgery was painless and made easy by virtue of having it performed in the doctor's office and by the consideration of the people in Dr. Chase's office. She agreed to speak to other patients about her favorable experience with cataract surgery. (Salatino at 64-65.)

342. Dr. Chase examined Ms. Salatino the day after the surgery on July 16th, and he and Ms. Salatino agreed that she would undergo cataract surgery on her left eye on July 22nd. (Ex. 501-JS-1-017.) However, that surgery did not occur because the Medical Practice Board suspended Dr. Chase's medical license on July 21, 2003.

343. Phil Ciotti contacted Ms. Salatino on July 22nd and told her she should have her eyes examined by another doctor, so Ms. Salatino made an appointment to see Dr. Irwin. (Salatino at 14-15.)

344. Dr. Irwin examined Ms. Salatino on July 25, 2003, saying about her operated eye "that is a fine piece of surgery." (Salatino at 69-70; Ex. 501-JS-2-001.)

345. Ms. Salatino informed Dr. Irwin's technician, who recorded it in her medical record, that she had been doing well and had no problems with the operated eye. Ms. Salatino said that she "had been having trouble with night driving and distance vision in general." She also complained to Dr. Irwin's technician that her unoperated left eye had a brown haze and that she noticed it now especially since having the surgery performed on her right eye. In Dr. Irwin's writing, there appears a notation that both eyes are blurry, eyes tired. (Ex. 501-JS-2-001.)

346. Ms. Salatino confirmed that she had told Dr. Irwin's technician that she had been having trouble with her night driving and distance vision in general, and explained that was why she had "gone and had the surgery," because driving was important to her. (Salatino at 72.) She said that after the surgery, everything she viewed through her operated right eye was clear and whiter and that things appeared discolored, beige, cream, browner or sepia out of her left eye.

(Salatino at 73-74.) She also explained that the gray circles on Dr. Chase's CST test chart had looked brown to her before she had the surgery. (Salatino at 75.)

347. Dr. Irwin diagnosed her with a bare trace cortical cataract in her left eye and no capsular opacities on the right eye. He found she had 20/20 best corrected Snellen vision in her left eye, but he did not perform contrast sensitivity testing. (Ex. 501-JS-2-002.) Dr. Freeman testified that the haze in Ms. Salatino's left eye is strongly associated with nuclear cataract and is not typically caused by trace cortical cataract. (Freeman, 12/18/06 at 195-96.)

348. Dr. Irwin found no condition in Ms. Salatino's eyes other than cataracts that would cause the visual symptoms she complained of to him and his staff. (Irwin at 222.)

349. Dr. Irwin told Ms. Salatino that he did not see anything in her left eye that needed surgery, and that made her "very, very, upset, angry" toward Dr. Chase. (Salatino at 15-16.) Three days later, on July 28, 2003, she filed a lawsuit against Dr. Chase accusing him of fraud, malpractice, assault and battery, and intentional infliction of emotional distress. (Salatino at 78-79; Ex. 720.)

350. Dr. Irwin wrote a memorandum for the Medical Practice Board on July 25, 2003, in which he stated:

that Ms. Salatino had presented to Dr. Chase "because her eyes were somewhat blurry and she said her eyes were tired at times." Ms. Salatino "denied symptoms of glare." She knew what a refraction was, but did not recall Dr. Chase performing one.

Dr. Irwin concluded by saying that she had a bare trace of lens opacity in her left eye that he did not consider to be a clinical cataract. (Ex. 501-JS-2-007.)

351. Dr. Irwin's memorandum to the Medical Practice Board omitted material facts contained in his own records. He did not include that his medical record demonstrated that Ms. Salatino had complained to his technician that she had been having trouble with night driving and distance vision in general before the surgery. He also failed to inform the board that Ms. Salatino reported that her unoperated left eye appeared to have a brown haze over it, and she particularly noticed it since the surgery. Contrary to Dr. Irwin's suggestion, Dr. Chase did perform a refraction on Ms. Salatino to determine her best corrected vision. Dr. Irwin did not mention in his memorandum Ms. Salatino's well below average performance on the contrast sensitivity test. He inaccurately said that the contrast sensitivity test had been performed while Ms. Salatino's eyes were dilated. (Ex. 501-JS-2-007; Irwin at 229-30, 232-39.)

352. Dr. Irwin testified at the hearing that “brown haze” is significant. (Irwin at 234.) He stated he did not know why he neglected to include Ms. Salatino’s symptoms in his memorandum. (Irwin at 236.) When asked if his memorandum to the Medical Practice Board omitting key facts had been fair to Dr. Chase, Dr. Irwin vacillated in his response, saying: “Maybe, don’t know... possibly. Don’t know.” (Irwin at 230-32.)

353. Dr. Irwin also testified that Ms. Salatino’s statements that she was unaware of her risk for glaucoma and that Dr. Chase had not refracted her, in light of Dr. Chase’s medical records clearly indicating the inaccuracy of those assertions, gave him reason to question Ms. Salatino’s recollection of her June 2003 examination by Dr. Chase. (Irwin at 241-242.)

354. Ms. Salatino was examined by the State’s expert ophthalmologist witness, Dr. Patrick Morhun, on September 5, 2003. She told Dr. Morhun that before the surgery she had not been having trouble with driving at night. (Ex. 501-JS-2-010; Salatino at 82.) That denial was directly contradicted by the medical records of both Dr. Chase and Dr. Irwin, which reflected that Ms. Salatino had complained that her vision was causing her difficulty driving at night. (Ex. 501-JS-2-001; 501-JS-1-007, 009, & 047.) She did not inform Dr. Morhun, as she had told Dr. Irwin’s staff, that her vision in her left, unoperated eye was like looking through a “brown haze”.

355. Dr. Morhun, unlike Dr. Irwin, observed a 1+ nuclear cataract in Ms. Salatino’s left eye. Unlike Dr. Irwin, Dr. Morhun failed to observe a cortical cataract in Ms. Salatino’s left eye. (Ex. 501-JS-2-011.)

356. Judith Salatino’s failure to recall her communications with Dr. Chase regarding glaucoma, her inaccurate denial that Dr. Chase had refracted her, her denial of driving problems to Dr. Morhun in direct contradiction to her statements to both Drs. Irwin and Chase, her failure to report the “brown haze” to Dr. Morhun, and her promptly filed lawsuit against Dr. Chase, seriously undermine her credibility regarding the details of her examinations by Dr. Chase.

3. Dr. Chase Acted Professionally As To Susan Lang (Patient #4)

357. Susan Lang testified at the merits hearing on October 2, 2006. Ms. Lang is a medical researcher at Fletcher Allen, where she assists in human research studies; as part of her job, she works extensively with medical professionals and reviews informed consent documents. (Lang at 24-25.)

358. Ms. Lang is part of a class action suit against Dr. Chase, in which she is seeking money damages from him. (Lang at 26-27.)

359. Until Ms. Lang read about Dr. Chase's license suspension in the newspaper, she never felt mistreated by him. (Lang at 27-28, 32.)

360. Susan Lang was first examined by Dr. Chase in 1977; she was a patient for over 25 years by the time Dr. Chase performed cataract surgery on her right eye on July 15, 2003. (Ex. 501-SL1-1-001, 020.)

361. Dr. Chase first diagnosed Ms. Lang with cataracts in 1990. (Ex. 501-SL1-1-003.)

362. Dr. Chase diagnosed Ms. Lang with cataracts in 1991, 1992, 1993, 1995, 1998, and 1999, but did not offer or recommend cataract surgery to her on any of these occasions because she was not complaining of symptoms attributable to her cataracts. (Ex. 501-SL1-1-002-013; Lang at 40-41; Chase, 9/21/06 at 129-30; Freeman, 1/8/07 at 72.)

363. In 2000, Ms. Lang complained of decreased vision in low illumination. (Chase, 10/21/06 at 136; Ex. 501-SL1-1-014.) In 2000, Ms. Lang also first complained of experiencing glare and halos when she was driving at night in the rain or snow. (Lang at 41-42.) Ms Lang was experiencing increased glare from oncoming headlights, which she experienced as a larger zone of diffused light around those headlights. (Lang at 42.) As a result, she felt that her vision was not as good as it had been, or as it should be. (Lang at 42.) Ms. Lang's visual symptoms were bothering her, and she had become uncomfortable driving at night many evenings. (Lang at 43.)

364. Ms. Lang's job required her to drive at night and in the rain and snow regularly. (Lang at 42.)

365. Ms. Lang's CST/BAT vision, as tested by Dr. Chase's technician in 2000, was well below normal for her age, measuring patch 1 on the 6 c/d column of the test, confirming her symptoms; this score was a significant drop from her 1999 CST/BAT score, which measured patch 5 and patch 3 in her left and right eyes respectively. (Compare Ex. 501-SL1-1-071 and 072.)

366. Dr. Chase concluded that her symptoms and CST/BAT deficit were caused by her cataracts, and identified no other cause for her symptoms or poor test scores. (Chase, 9/21/06 at 136.)

367. Dr. Chase told Ms. Lang that he believed that her symptoms were being caused by her cataracts and that he could perform cataract surgery if she wanted to eliminate the symptoms; however, he did not try to push her toward surgery in any way. (Lang at 44.)

368. Ms. Lang asked if there were any alternatives to surgery, and Dr. Chase immediately suggested that she could try an anti-reflective coating on her glasses. (Lang at 44.) Ms. Lang tried the anti-reflective coating, but it did not eliminate the symptoms she was experiencing. (Lang at 44-45.)

369. Although Dr. Chase offered Ms. Lang cataract surgery in 2000, and she declined that surgery in favor of anti-glare treatment on her glasses, she was satisfied with the care she received in 2000 and returned for an examination by Dr. Chase in 2002. (Lang at 28.)

370. The State has not alleged that Dr. Chase's offer of surgery to Ms. Lang in 2000 was improper in any way.

371. When Ms. Lang returned in 2002, she filled out an Eye Health History form, on which she indicated that she was "currently" being "bothered by" "glare" and "halos." (Ex. 501-SL1-1-024.)

372. Although Ms. Lang wrote that she was "currently" experiencing these problems, at the merits hearing, Ms. Lang maintained that, in filling out this form, she did not intend to convey that she was actually experiencing these symptoms in real life. Instead, she testified that she intended to convey that she would have experienced glare and halos when driving at night without her glasses, but that she never drove at night without her glasses. (Lang at 48-51.) Ms. Lang's testimony that she only intended to convey her symptoms when driving without glasses (which she never did) is nonsensical.

373. Ms. Lang testified that her glare and halos were not bothering her in 2002. Dr. Chase told her that he could not recommend cataract surgery to her unless she had complaints associated with her cataracts. In response, Ms. Lang did not voice any complaints, and Dr. Chase did not offer her cataract surgery. He did not attempt to pressure her into voicing a complaint, and he did not suggest that she articulate complaints that were not true. (Lang at 58-59.)

374. At the same 2002 visit, Dr. Chase showed Ms. Lang the results of her CST/BAT. Ms. Lang agreed that there was nothing wrong with Dr. Chase showing her those test results; indeed, she testified that she would expect her doctor to show her any test results indicating a problem with her ocular health, and that she would be upset if the doctor did not show her such results. (Lang at 56-57.)

375. Although she later testified that Dr. Chase's demeanor during her 2002 examination made her uncomfortable, Ms. Lang returned to Dr. Chase for an examination in 2003, rather than seeking out a new eye doctor. (Lang at 28-29.)

376. During her June 30, 2003 examination, Ms. Lang updated her Eye Health History form with Dr. Chase's technician. (Ex. 501-SL1-1-025; Chase, 9/21/06 at 139.) On that form, she indicated that she was "currently experiencing" halos and was "bothered by glare." (Ex. 501-SL1-1-024.)

377. She also complained to Dr. Chase that she was having trouble seeing a small scientific instrument at her work. (Lang at 15-16, 61.) It was important that Ms. Lang be able to see this instrument well, because it was susceptible to breakage. (*Id.*) Ms. Lang further informed Dr. Chase that she was bothered by the bright lights that she used at work in order to see the small parts of scientific instruments. (Lang at 15-16, 62.)

378. Dr. Chase's technicians performed two CST/BATs on Ms. Lang during the course of her June 30, 2003 examination. (Ex. 501-SL1-1-068, 069.) One of the tests was performed prior to dilation, one was performed after dilation, and both test scores were recorded in Ms. Lang's chart. (*Id.*) Both test scores showed that Ms. Lang's contrast sensitivity and glare vision was 73% below the very bottom of the normal range for her age and 85% to 90% below the average. (Evans at 208-09; Freeman, 1/8/07 at 75-76.)

379. On June 20, 2003, Dr. Chase measured Ms. Lang's best corrected Snellen vision as 20/40 in both eyes. (Ex. 501-SL1-1-068.)

380. Dr. Chase's examination revealed no cause other than cataracts for her symptoms or low vision test scores, including her glasses prescription. (Freeman, 1/8/07 at 74.)

381. Dr. Chase reasonably concluded that Ms. Lang's cataracts were responsible for her symptoms and her below-normal CST/BAT scores and that cataract surgery would improve her vision; his examination revealed no other cause for her vision problems. (Chase, 9/21/06 at 140-41.)

382. Dr. Chase reasonably offered Ms. Lang cataract surgery, and told her, as he told all of his potential surgery patients: "[If] you go to any other medical eye doctor in the area and say I've come for a second opinion, Dr. Chase says I have cataracts and I need cataract surgery, and the doctor will tell you that if you see well enough to suit you, its not going to damage your eyes not to have cataract surgery." (Chase, 9/21/06 at 121-22.)

383. In giving this presentation to Ms. Lang, Dr. Chase was not intending to discourage her from getting a second opinion; rather, he was attempting to reinforce the fact that cataract surgery is an elective procedure, cataracts do not need to be taken out, and that the patient's "vision is the determining factor." (Chase, 9/21/06 at 122.)

384. Ms. Lang understood that it was her choice as to whether to go forward with cataract surgery. (Lang at 66.) Ms. Lang made an appointment to come back on July 3, 2004 to participate in the informed consent process with Dr. Chase's nurse. (Lang at 67; Ex. 501-SL1-1-020.)

385. The nurse discussed the informed consent packet with Ms. Lang in detail, asked her to take it home and read it and to call if she had any questions. (Lang at 67-68.) Ms. Lang testified that she is very familiar with informed consents, both as a patient and as a researcher, and that Dr. Chase's informed consent materials were very thorough. (Lang at 68.)

386. 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 that she wanted to go forward with surgery. (Lang at 68-69.)

387. In 2003, no one placed any pressure on Ms. Lang to have cataract surgery. (Lang at 69-70.)

388. Ms. Lang chose to go forward with cataract surgery on her right eye on July 15, 2003. (Lang at 69; Ex. 501-SL1-1-020.)

389. After the surgery, the glare that Ms. Lang experienced in her right eye was eliminated. (Lang at 75-76.) She still experiences difficulty seeing small objects out of her left, unoperated eye. (Lang at 76-77.)

390. After cataract surgery on her right eye was complete, Ms. Lang was so satisfied with the care she had received that she was planning on having cataract surgery on her left eye. (Lang at 29-30.)

391. She even went so far as to fill out a patient survey, in which she indicated that she was very satisfied with the care she had received and that Dr. Chase's staff was very professional and kind; she agreed to speak positively to other potential surgical candidates about her experience. (Ex. 694; Lang at 30-31.)

392. Dr. Chase's license was suspended after Ms. Lang's right eye surgery but before her left eye surgery. (Lang at 77.) Because of the license suspension, Ms. Lang went to see Dr. Tabin for follow up care regarding her recently-performed right eye surgery.

393. Dr. Tabin informed Ms. Lang that she had received well-performed surgery on her right eye, with a good visual result, and offered no opinion on whether that surgery had been necessary or unnecessary. (Lang at 33-34; Tabin at 79.)

394. Dr. Tabin performed a dilated refraction of Ms. Lang's right eye, but the fact that the refraction was done with the patient's eye in a dilated state was not recorded in Dr. Tabin's chart. (Tabin at 81; Ex. 501-SL1-2-003.)

395. Dr. Tabin confirmed that Ms. Lang had a cataract in her left eye, but she did not report any of her visual symptoms to him, and denied having any problems with glare. (Lang 78-79; Tabin at 83.) Dr. Tabin did not perform glare testing or contrast sensitivity testing on Ms. Lang. Because she reported no significant symptoms, Dr. Tabin did not recommend cataract surgery to Ms. Lang. (Tabin at 31.)

396. Dr. Tabin and his successor, Dr. Pecsényicki, diagnosed Ms. Lang with nuclear, cortical, and posterior subcapsular cataracts in her left eye on subsequent visits. (Ex. 501-SL1-2-001, 005, 011, 037.)

397. Despite the fact that she had received no medical opinion that her cataract surgery had been improper or poorly performed, and despite the fact she had excellent vision in her operated eye, on August 18, 2003, Ms. Lang filed a complaint with the Board, alleging that Dr. Chase had performed unnecessary cataract surgery, echoing the charges she had read about in the newspaper. (Lang at 33-39.)

398. Today, Ms. Lang has "very good" vision in the right eye on which Dr. Chase performed cataract surgery. (Lang at 34.)

4. Dr. Chase Acted Professionally As To Marylen Grigas (Patient # 5)

399. Marilyn Grigas testified on November 8, 2006. She and her family began seeing Dr. Chase for ophthalmological care in 1981. She appreciated his direct and business like manner of communicating and thought he was very professional. (Grigas at 143, 149.)

400. Ms. Grigas had enjoyed excellent vision during most of her life. (Grigas at 151.)

401. She was first diagnosed with bilateral cataracts by Dr. Chase during an examination in 1997 when she was 55 years old. (Grigas at 150; Ex. 501-MG-1-012.) However,

even then she had no visual complaints and Dr. Chase informed her the cataracts were not affecting her vision and required no action other than monitoring for visual symptoms. (Grigas at 150-51). Dr. Chase advised Ms. Grigas' primary care physician of her cataract diagnosis. (Ex. 501-MG-1-079.)

402. Ms. Grigas was examined by Dr. Chase again in 1998 and no action was taken with respect to her cataracts as they were not affecting her vision. (Ex. 501-MG-1-013-014.)

403. Dr. Chase examined Ms. Grigas' eyes in 1999 and found that both her contrast sensitivity test and Snellen test scores were above normal. She was able to see patch 5 and 7 on the CST with glare test. (Ex. 501-MG-1-015, 051.) He continued to monitor her cataracts.

404. Dr. Chase examined Ms. Grigas' eyes again in both 2000, (Ex. 501-MG-1-017-018), and 2001. (Ex. 501-MG-1-019-020.) It was determined during Ms. Grigas' 2001 examination that her cataracts had affected her Snellen vision and that her spectacle prescription needed to be changed to address her symptoms. Dr. Chase provided new spectacles to Ms. Grigas with the new prescription, (Ex. 501-MG-1-052), and informed Ms. Grigas' primary care physician of the change. (Ex. 501-MG-1-076.) Ms. Grigas' contrast sensitivity with glare test scores continued to be in the normal range with Ms. Grigas seeing patch 5 in both eyes. (Ex. 501-MG-1-048.)

405. During the five years and five eye examinations Marilyn Grigas had between 1997 and 2001, she expressed no significant functional vision complaint related to her cataracts, her contrast sensitivity with glare test scores were normal or above, and Dr. Chase did not discuss cataract surgery with Ms. Grigas and instead simply monitored her cataracts and addressed change in her vision by prescribing new glasses. (Grigas at 158.)

406. Dr. Chase examined Ms. Grigas' eyes again on September 9, 2002, when she was 59 years old. (Ex. 501-MG-1-021-023.) She informed him that she had difficulty driving at night, had darker vision in general, and that she was bothered by glare. (Grigas at 161-168; Ex. 501-MG-1-035). Ms. Grigas' contrast sensitivity test results declined significantly between her 2001 examination and her September 9, 2002 examination, falling from patch 5 in both eyes to patch 2 and 3, respectively, in her left and right eyes. (Ex. 501-MG-1-047.) Ms. Grigas' contrast sensitivity was 60% below the bottom of the normal range for her age and 85% below the average. (Evans at 208-09.)

407. Marilyn Grigas had a general recollection of Dr. Chase informing her that there had been a significant decline in her contrast sensitivity since her last examination. (Grigas at 160-61.) Even before her 2002 examination she had noticed her vision had declined in dim light and that night driving had become more difficult. She had suspected cataracts were the cause. (Grigas at 168-69.)

408. Dr. Chase informed her that after listening to her visual problems, examining her lenses and reviewing her objective test scores, he believed that her cataracts were interfering with her vision and causing her visual problems and that surgery would help. (Grigas at 167, 170, 230.) Ms. Grigas thought she would get some pamphlets, think about it and then have the cataracts removed later that year. (Grigas at 143-44.) She recalls Dr. Chase saying that he had an opening on his surgical schedule the next day. (Grigas at 144, 171.) Ms. Grigas said she had a play rehearsal the next day and Dr. Chase said it would not be a problem. (Grigas at 144.)

409. Dr. Chase summarized the risks and benefits of the surgery and told Ms. Grigas that she should meet with the nurse who would give her additional information. She never told Dr. Chase that she did not want the surgery. (Grigas at 171-72.) In fact, she thought she would have the surgery, but she was concerned with the quickness with which she thought it was being scheduled. (Grigas at 170.)

410. Ms. Grigas nonetheless 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. (Ex. 501-MG-1-035.)

411. When Ms. Grigas met with the nurse, Susan Grohn, she found her to be very professional and helpful and she viewed Ms. Grohn as a patient advocate. (Grigas at 173.) Ms. Grigas recalls asking Grohn if she could attend a play rehearsal the next day and Grohn said most people prefer to sleep. She told the nurse that she did not want to have the surgery the next day, and Ms. Grohn said do not do anything unless you want to do it. 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. (Grigas at 145.)

412. Ms. Grigas 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, (Grigas at 41), but that recollection is directly and substantially contradicted by Dr. Chase's medical records and the records produced by Ms. Grigas (both of which were recorded by Susan Grohn).

413. 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. (Ex. 501-MG-1-023.) 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 that week and would discuss it with her. Cataract surgery on Ms. Grigas' left eye was scheduled for 6:30 a.m. on October 1, 2002, and that Ms. Grigas was instructed to begin her pre-operative drops on September 28, 2002. (Ex. 501-MG-1-023.) Nurse Grohn made another entry on September 16, 2002 stating that she had notified Dr. Sandoval of Ms. Grigas' October 1st left eye surgery and that it would be under local anesthesia. On September 17th, 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. (Ex. 501-MG-1-023; 501-MG-1-034.)

414. 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. She had a single appointment card provided by Susan Grohn showing that she was scheduled for surgery on October 1st at 6:30 a.m. (Ex. 616-002.) Ms. Grigas produced a prescription for preoperative eye drops given to her by Dr. Chase on September 9th, (Ex. 616-002), with instructions signed by both Ms. Grigas and Susan Grohn directing her to begin the drops on September 28th and continue until her surgery on October 1st for her left eye. (Ex. 616-017.)

415. 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." (Grigas at 192, 195.) She later said "maybe my memory is suspect" but maybe the records are also suspect. (Grigas at 206.) She offered no basis for the records being suspect other than that they did not comport with her recollection.

416. 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. (Grigas at 148.) When asked if she got new spectacles in 2001 when her prescription

changed from her cataracts she replied several times that she “did not.” (Grigas at 157.) When asked if she was sure of that, Ms. Grigas replied “Quite.” (Grigas at 158.) In fact, the records show that she received and was charged for new glasses on August 22, 2001, (Ex. 501-MG-1-051), and on July 15, 1999. (Ex. 501-MG-1-052.)

417. 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. The Board does not question Ms. Grigas’ honesty, but does find that her recollection was inaccurate with respect to the date her tentative surgery had been scheduled.

418. Marilyn Grigas produced pamphlets and an informed consent form that Susan Grohn had provided to her on September 9. (Ex. 616-003-016, & 616-018.) She testified that Susan Grohn had gone over those materials with her and on September 9, Ms. Grigas was aware that the decision to have cataract surgery was hers to make, it would not jeopardize the outcome to delay the surgery, and that she should not have the surgery unless cataract induced vision loss was preventing her from doing something she needed or wanted to do. (Grigas at 182-83.)

419. About a year after her 2002 examination, Ms. Grigas read about Dr. Chase’s suspension in the newspaper and decided to write a complaint to the Medical Practice Board. (Grigas at 208.) She testified that her complaint related only to the speed between the offer of cataract surgery and what she believed was the scheduled surgery date; it did *not* relate to Dr. Chase’s decision to offer her the surgery. (Grigas at 211.)

420. Thereafter, Ms. Grigas had her eyes examined by Dr. Cavin on September 12, 2003. Dr. Cavin’s records reflect that Ms. Grigas informed his office that her vision was good and “driving at night not a problem. No glare per patient.” (Ex. 501-MG-2-001.) He diagnosed her with cortical cataracts in both eyes with the left being slightly more significant than the right, but noted that Ms. Grigas said she was getting along well with her vision. He thus concluded the cataracts were relatively clinically insignificant. (Ex. 501-MG-2-002.) In follow-up examinations he diagnosed her with both nuclear and cortical cataracts, or combined cataracts, and after discussing surgery at length with Ms. Grigas, did not recommend it because Ms. Grigas said she was not having vision problems. (Ex. 501-MG-2-005-009.)

421. In Dr. Freeman’s opinion it was reasonable for Dr. Chase to offer surgery to Marilyn Grigas. (Freeman, 12/18/06 at 185.) Ms. Grigas’ report to Dr. Cavin regarding her vision was fundamentally different than the complaints she made (some in her own handwriting)

regarding her visual symptoms to Dr. Chase and his staff. Because Ms. Grigas made no vision complaints to Dr. Cavin, his decision not to offer surgery to her was reasonable. (Freeman, 12/18/06 at 186.) It was this dramatic difference in her visual symptoms that explain completely why Dr. Chase offered her surgery for her cataracts and Dr. Cavin did not.

5. Dr. Chase Acted Professionally As To Donald Olson (Patient # 7)

422. Donald Olson, a retired dental educator, testified on October 2, 2006. He was examined by Dr. Chase on a single occasion on September 9, 1995 when he was 63 years old. (Olson at 98-99; Ex. 501-DO-1-001.)

423. Dr. Olson first filed a complaint with the Medical Practice Board eight years later after reading and hearing publicity regarding the suspension of Dr. Chase's license in July 2003. (Olson at 136-37.)

424. Dr. Olson had numerous symptoms of visual impairment when he was examined by Dr. Chase in September, 1995. He 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. (Olson at 110-11; Ex. 501-DO-1-001.) 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. (Olson at 117-20; Ex. 501-DO 1-001.) 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. (Olson at 115-16.)

425. Dr. Olson thought he was seeing fairly well when he visited Dr. Chase, but actually he had failed to appreciate that his Snellen vision with his existing glasses had declined significantly to 20/40 and 20/50. By changing his prescription, Dr. Chase was able to improve his Snellen vision to 20/25 in both eyes. (Ex. 501-DO-1-001.) However, his contrast sensitivity with glare test result, achieved with his very best corrected vision, was no better than 20/100. (Ex. 501-DO-1-004.) His contrast sensitivity was 73% below the bottom of the normal range for his age and 85% to 90% below the average. (Evans at 208-09.)

426. Dr. Chase diagnosed Dr. Olson with cataracts in both eyes, with the opacification being more advanced in his right eye than his left eye. (Ex. 501-DO-1-001.) Historically, Dr. Olson's left eye had the weakest vision due to possible amblyopia, but he noticed that that at some point after being diagnosed with cataracts by Dr. Chase his right eye had become his weaker eye. (Olson at 111-12.)

427. 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. He has no specific recollection of Dr. Chase telling him that if he wanted to correct his vision he needed surgery. (Olson at 121.) Dr. Chase did not advise him about the risks or benefits of surgery and definitely did not pressure him to have surgery. (Olson at 122.)

428. Dr. Chase's medical records for Dr. Olson, unlike the records of each of the other 10 patients comprised by the State's charges, do not mention any discussion regarding cataract surgery. (Ex. 501-DO-1-001-003 & 010.)

429. Dr. Olson was next examined by Dr. Guilfooy on January 20, 1998. Dr. Guilfooy diagnosed him with moderate nuclear cataracts in both eyes. Dr. Olson's Snellen vision was 20/40 and 20/30 with his existing spectacles, although Dr. Guilfooy was able to correct that with a new prescription to 20/20-2 and 20/25-3. (Ex. 501-DO-2-002-004.) Dr. Guilfooy could not say how long Dr. Olson had been seeing poorly from his existing spectacles. (Guilfooy at 246.) Dr. Guilfooy attributed Dr. Olson's diminution in vision entirely to cataracts. He explained the cataracts were causing Dr. Olson to experience myopic shifts. (Guilfooy at 249.)

430. Dr. Guilfooy's records do not indicate that he ever performed a dilated slit lamp exam on Dr. Olson, which is necessary in order to permit the doctor to conduct an adequate physical examination of the patient's lenses. Dr. Guilfooy testified that he probably never did a dilated slip lamp exam on Dr. Olson. (Guilfooy at 250, 253.) Dr. Guilfooy explained that he uses a general Snellen threshold of 20/40 and an absolute Snellen threshold of 20/30 before he will offer cataract surgery to a patient. (Guilfooy at 180-82, 212-13, 221-24, 231.) If a patient can be refracted to a best corrected vision better than 20/40 Snellen, Dr. Guilfooy generally dispenses with a dilated slip lamp exam because no matter what he sees in the lens he will not offer surgery. (Guilfooy at 211-12.) Because Dr. Guilfooy was able to correct Dr. Olson to better than 20/40 Snellen on each of his several visits, it appears that Dr. Guilfooy never did a dilated slip lamp examination of Dr. Olson.

431. Dr. Olson testified that Dr. Guilfooy informed him that his cataracts were not significant enough to warrant surgery, (Olson at 124-26), which as Dr. Guilfooy explained, means his best corrected Snellen vision was no worse than 20/40. Dr. Guilfooy does not conduct glare or contrast sensitivity testing in his practice. (Guilfooy at 132, 186.)

432. Dr. Guilfooy examined Dr. Olson on March 25, 2000 and described his cataracts as being moderately severe in both eyes. (Ex. 501-DO-2-005.) He did not test his incoming Snellen vision, but was able to correct his Snellen vision to 20/25-2 and 20/25-1, noting a continued myopic shift in his right eye. (Guilfooy at 251.)

433. Dr. Guilfooy examined Dr. Olson on June 26, 2001, and found his Snellen vision with existing glasses was 20/40 and 20/25-2. Dr. Guilfooy said he was continuing to experience myopic shifting, but was able to correct his Snellen vision to an acceptable level. (Guilfooy at 254.)

434. In January 29, 2004, Dr. Olson thought he was seeing well when he went to see Dr. Guilfooy for an examination, but his Snellen vision with existing glasses was 20/40-1 and 20/40 -2. The best that Dr. Guilfooy could correct his Snellen vision to was 20/30 and 20/25-2. Dr. Olson apparently did not recognize his poor incoming vision, as Dr. Guilfooy's records indicate "patient does not note any difficulties." (Guilfooy at 256; Ex. 501-DO-2-007.) Dr. Guilfooy did not inform Dr. Olson as to the deficiency in either his incoming Snellen vision nor his best corrected Snellen vision. (Olson at 128-131.) Dr. Guilfooy's records describe Dr. Olson's cataracts as being moderately severe. (Ex. 501-DO-2-007-008.)

435. Dr. Guilfooy retired and Dr. Olson was examined by Dr. Cavin in 2006. His incoming Snellen vision with his existing glasses prescription was 20/60-2 and 20/40-1. (Guilfooy at 259.) Dr. Cavin performed cataract surgery on both of Dr. Olson's eyes in 2006. (Olson at 134-36.) Dr. Olson is happy he had the surgery.

436. Dr. Olson's cataracts were causing myopic shifts in his Snellen vision during the 8-year period between 1998, when he started seeing Dr. Guilfooy, and his cataract surgery in 2006. Although Dr. Guilfooy changed his prescription on each visit, each time Dr. Olson returned his Snellen vision had declined, often to levels below the legal driving limit of 20/40. Dr. Guilfooy repeatedly testified that when Dr. Olson presented with deficient incoming Snellen vision, there was no way to know for how long he had been experiencing the impairment in his Snellen vision. (Guilfooy at 254, 257-59.)

437. During the entire period between Dr. Olson's initial visit to Dr. Guilfooy in 1998 and his cataract surgery in 2006, Dr. Olson had not reduced either his day or night driving. (Olson at 131-33.)

438. Dr. Olson refused a request by Dr. Chase's attorney to have an independent examination performed on his eyes in 2004. (Olson at 135-36.) He also refused a request to provide Dr. Cavin's records of his examination of Dr. Olson. No one from the Attorney General's Office interviewed him before issuing the specification of charges and Dr. Olson has never read those charges. (Olson at 136-37.)

6. Dr. Chase Acted Professionally As To Jane Corning (Patient # 8)

439. Jane Corning testified on October 3, 2006. She was first examined by Dr. Chase on August 1, 1996 when she was 53 years old. She complained of problems with her near vision. Dr. Chase did *not* diagnose her with cataracts. With a prescription change, she was able to see above average on the Snellen chart, testing at 20/15 in both eyes. (Ex. 501-JC-1-001-002; Corning at 234-38)

440. Dr. Chase's demeanor and manner of communicating was very businesslike and straightforward; he was not talkative. Ms. Corning decided to find an ophthalmologist that was more complementary to her particular needs and with whom she was more comfortable. (Corning at 238.)

441. After seeing a different ophthalmologist, Ms. Corning scheduled another appointment for an eye examination by Dr. Chase on June 30, 2000. During that visit Ms. Corning indicated on her Eye Health History form that she was bothered by glare, (Ex. 501-JC-1-007; Corning at 24), and she told Dr. Chase's technician that she was bothered by glare when driving on wet roads at night. (Ex. 501-JC-1-004; Corning at 240-41.)

442. Ms. Corning's best corrected Snellen vision test score was 20/20 in her right eye and 20/25 in her left eye. (Ex. 501-JC-1-017.) This represented a one line drop in the right eye and a two line drop in the left eye from the Snellen test results she had achieved four years earlier in 1996.

443. Ms. Corning's contrast sensitivity test with glare score in each eye was Patch 2, which was substantially below normal for her age. (Ex. 501-JC-1-017.) The first page of Dr. Chase's examination record for June 30, 2000 clearly reflect Ms. Corning's deficient contrast sensitivity by expressing it in its Snellen equivalent of 20/70 in both eyes and clearly labeling that score as being "CSTw/BAT." Her contrast sensitivity was 60% below the bottom of the normal range for her age and 85% to 90% below the average. (Evans at 208-09.)

444. Dr. Chase diagnosed Ms. Corning as having cataracts in both eyes, used the word dense to mean they were visually significant, and described them as being nuclear and cortical with respect to their location in the lens. (Ex. 501-JC-1-003.) After evaluating Ms. Corning's objective test scores, her visual complaints and his observations of her lenses during the dilated slit lamp examination, Dr. Chase properly concluded that Ms. Corning was not seeing clearly in glare because it was interfering with her vision, and he noted his conclusion on his medical record. (Ex. 501-JC-1-004.)

445. Dr. Chase informed Ms. Corning that she had cataracts in both eyes, that they were visually significant, and that cataract surgery would be appropriate to correct their effect on Ms. Corning's vision. Dr. Chase did not, to Ms. Corning's recollection, tell Ms. Corning that she "needed" to have the surgery. (Corning at 246.) Dr. Freeman testified that it was reasonable for Dr. Chase to offer Ms. Corning cataract surgery. (Freeman, 12/18/06 at 203-04.)

446. She was "shocked," worried and upset to learn she had cataracts, (Corning at 244-45), although Dr. Chase never raised his voice or spoke in a threatening way to her. (Corning at 250.)

447. While Dr. Chase was informing her that she had cataracts that would justify surgery, Ms. Corning noticed that his hands were shaking and firmly decided at that point that there was no way she would permit Dr. Chase to perform surgery on her. (Corning at 246.)

448. Ms. Corning's recollection is that Dr. Chase suggested that she could be scheduled for surgery the following Tuesday which, given that the exam day was Friday, June 30th, meant July 4th, although Ms. Corning was not then aware that the following Tuesday was July 4. (Corning at 247-48, 258.) In fact, Dr. Chase's office was closed on July 4th and no surgery was scheduled for that day. (Ex. 676; Corning at 249.) Ms. Corning conceded that she might have been mistaken in thinking Dr. Chase meant Tuesday, July 4th rather than July 11th or 18th. (Corning at 253, 259.)

449. Jane Corning felt very upset and rushed for three reasons: (1) she was shocked and upset to learn she had cataracts; (2) she thought she was being scheduled for surgery four days later on July 4th, which was too soon for her to evaluate the decision; and (3) Dr. Chase's hands were shaking. (Corning at 248-49, 260.)

450. Dr. Chase told Ms. Corning to see the nurse, and Ms. Corning went to do so without communicating to him that she had decided in her own mind not to have the surgery.

(Corning at 266, 271.) Dr. Chase concluded that she wanted to have the surgery and he reasonably noted that on the first page of her medical record. (Ex. 501-JC-1-004.)

451. Ms. Corning acknowledged that Dr. Chase may have informed her the nurse would explain in detail the nature, risks and benefits of the surgery and give her written information to take home and consider, but Ms. Corning had already made up her mind she was not having it and she was not focused on what he was saying. (Corning at 255.) When the nurse offered her printed material to take and read, Ms. Corning refused it. (Corning at 255.)

452. Ms. Corning acknowledged it would have been very helpful to her on June 30, 2000, if she had read and considered the information in the printed material offered her and stating that the decision to have cataract surgery was hers to make, she should not have the surgery unless the cataracts were preventing her from doing something she wanted or needed to do, and that it would not hurt her to delay having such surgery. (Corning at 264-65.)

453. Dr. Chase's records reflect that Ms. Corning was never scheduled for surgery because she told the nurse that she wanted to discuss the issue with her husband and research it on the internet before deciding, and that she would call back in the fall. Ms. Corning concedes that she may have made this statement to the nurse. (Ex. 501-JC-1-003; Corning at 272-73.) Thus the complete medical record clearly reflects that on June 30, 2000, the examination concluded with Ms. Corning deciding to defer the decision regarding cataract surgery.

454. On September 12, 2000, Dr. Chase, at the request of Jane Corning, forwarded to Dr. Irwin a summary of his medical record for his June 30, 2000 examination of Ms. Corning. That summary reflected that Ms. Corning's CST with BAT test results, expressed in its Snellen equivalency, was 20/70 in each eye, that Dr. Chase had diagnosed her as having bilateral cataracts and discussed surgery with her, and the correct refraction for Ms. Corning. (Ex. 501-JC-1-015.)

455. On October 5, 2000, Jane Corning saw Dr. Irwin for a second opinion regarding cataract surgery. She complained on that visit that she had difficulty driving at night with wet roads and seeing close objects but that reading was not too bad. (Ex. 501-JC-2-002; Corning at 275.) Ms. Corning recalls that Dr. Irwin informed her that she did not have cataracts and that if she was to have a problem from cataracts, it would not develop until 20 years down the road. (Corning at 230, 275.) He did not tell her that her best corrected Snellen vision in her left eye was 20/25 and that her visual acuity in each eye dropped two lines when tested with the BAT on

medium. (Corning at 277-78.) Dr. Freeman testified that he would have discussed a two-line drop in glare vision with this patient. (Freeman, 12/18/06 at 211.) After learning about her decreased vision in glare during the hearing, Ms. Corning said she would be sure to ask questions about her vision in glare from cataracts in the future. (Corning at 294.)

456. Dr. Irwin's medical records for his examination of Ms. Corning reflect her complaints regarding glare and close vision, that he diagnosed her with bilateral cortical cataracts that he rated as "trace", that her best corrected snellen score was 20/20, 20/25 (the same as Dr. Chase's), and that her Snellen scores the BAT on medium were 20/30, 20/40. (Ex. 501-JC-2-001-002.)

457. Dr. Irwin found nothing in his examination of Ms. Corning's eyes other than her cataracts that explain her subjective complaints with glare while driving at night or to explain why her vision decreased when subjected to the BAT. (Irwin at 198.)

458. Dr. Irwin testified that there is nothing wrong with performing cataract surgery four days after the recommendation in the absence of a specific reason not to do so. (Irwin at 202.)

459. Dr. Irwin wrote a letter to Ms. Corning's primary care physician on October 19, 2000. In pertinent part, he wrote: "[Dr. Chase] had recommended [Jane Corning] to have cataract surgery on an urgent basis. She has a bit of difficulty driving on rainy nights (don't we all!)." He also reported that her "vision dropped slightly to 20/30 and 20/40 respectively when subjected to glare conditions" and said "there is just barely enough lens opacity to call it a cataract." He explained that her near vision problem could not be completely addressed with spectacles because her bifocals needed to be set at 14-16 inches for reading and were virtually useless to her when performing tasks at 5-6 inches (e.g., threading a needle). (Ex. 501-JC-2-003.)

460. On June 4, 2004, Jane Corning was examined by Dr. Tabin. She complained she was bothered by glare, floaters and flashes of light. (Ex. 501-JC-2-004.) He diagnosed her as having bilateral nuclear cataracts that he rated, using his rating system, as trace. (Ex. 501-JC-2-006-007.)

461. Jane Corning reported that she was bothered by glare, and confirmed that fact at the hearing. (Corning at 240-41; Ex. 501-JC-1-004, 007.)

462. Jane Corning first filed a complaint regarding her June 2000, examination with Dr. Chase over three years later after she saw publicity regarding the July 21, 2003 suspension of his license. (Corning at 294-295.)

7. Dr. Chase Acted Professionally As To Franklin Cole (Patient # 10)

463. Frank Cole testified on September 26, 2006. He was last examined by Dr. Chase over 14 years ago, in 1992. The State alleges that Dr. Chase acted unprofessionally when he diagnosed Mr. Cole with glaucoma and cataracts and offered him combined surgery to cure both diseases.

464. 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 and loss of retinal ganglion cells and their axions. (Ex. 506 at 5, American Academy of Ophthalmology Preferred Practice Pattern, Primary Open Angle Glaucoma (hereinafter “Glaucoma AAO PPP”; Cleary at 62; Freeman, 1/8/07 at 4.)

465. If left untreated, glaucoma leads to progressive and irreversible blindness, beginning with visual field loss at the periphery and/or in the center of the visual field. (Chase, 9/25/06 at 15; Cleary at 68; Freeman, 1/8/07 at 12.)

466. As a result, early intervention is particularly important in treating glaucoma. (Cleary at 69; Freeman, 1/8/07 at 12.) Doctors should always err on the side of treatment. (Freeman, 1/8/07 at 12.)

467. Glaucoma is one of the leading causes of blindness in the United States, and approximately half of those with glaucoma may be unaware that they have the disease. (Ex. 506, Glaucoma AAO PPP at 6; Cleary at 68.)

468. Measuring IOP is not an effective method of glaucoma screening because half of all individuals with glaucoma have normal pressures and most individuals with elevated pressures do not have optic nerve damage. (Ex. 506 at 11, Glaucoma AAO PPP; Cleary at 71-72; Freeman, 1/8/07 at 5.)

469. 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 (e.g., 1 to 5 years). (Ex. 506, Glaucoma AAO

PPP at 13, 18.) The single most important indicator of glaucoma is the appearance of the optic nerve, which can only be assessed through a dilated pupil. (Freeman, 1/8/07 at 12-16.)

470. In evaluating a glaucoma patient, the ophthalmologist should document an inability or decision not to dilate, including the reasons therefore. (Ex. 506, Glaucoma AAO PPP at 13.)

471. Mr. Cole filed a complaint with the Medical Practice Board alleging, among other things, the following: (1) that Dr. Chase had diagnosed him with glaucoma and unnecessarily treated his glaucoma with prescription eye drops beginning on his first visit in 1982 and continuing through his final visit with Dr. Chase in 1992; (2) that Dr. Chase had unnecessarily required him to be examined every six months in order to monitor his glaucoma, and that he reliably attended his appointments every six months; (3) that Dr. Chase offered him combined cataract and glaucoma surgery in 1992, but that two other ophthalmologists, Dr. Karen Cleary and Dr. Kathleen Maguire, informed him that he did not have cataracts and did not have glaucoma. (Cole 101-120.)

472. Mr. Cole was mistaken in his recollection regarding these important events, as evidence, by the examination notes of Drs. Chase, Cleary, and Maguire: (1) Dr. Chase did not diagnose Mr. Cole as having glaucoma, or begin treating his glaucoma with eye drops, until 1988, (Ex. 501-FC-1-005); (2) Mr. Cole often missed his appointments with Dr. Chase, (Ex. 501-FC-1-006, 010, 011), and at times went two years without an examination by Dr. Chase, (Ex. 501-FC-1-003-005); (3) Mr. Cole was diagnosed as having cataracts in both eyes by both Dr. Cleary and Dr. Maguire, (Ex. 501-FC-2-001, 032); (4) Dr. Maguire did not even examine Mr. Cole for the presence of glaucoma. (Ex. 501-FC-2-031-032.)

473. Mr. Cole was also mistaken in his recollection of other important facts. For instance, Mr. Cole was "quite certain" that Dr. Cleary had referred him to Dr. Maguire in 1992 for a third opinion on whether or not he had cataracts and glaucoma, and that he had never experienced any other visual problems that necessitated an examination by Dr. Maguire, a retinal specialist. In fact, Dr. Cleary referred Mr. Cole to Dr. Maguire three years later, in 1995, in order to address symptoms of wavy vision that Mr. Cole had been experiencing and which were caused by central serous retinopathy. (Cole at 115-117.) Mr. Cole specifically testified that he remembered Dr. Maguire telling him that he did not have cataracts. In fact, Dr. Maguire's

records indicate that Mr. Cole had nuclear, cortical, and posterior subcapsular cataracts in both of his eyes. (Ex. 501-FC-2-032.)

474. Mr. Cole's recollection of relevant events is not a sufficiently reliable basis on which to premise any finding that Dr. Chase acted unprofessionally in treating him over 14 years ago.

475. Neither the Board's investigator nor the State interviewed Mr. Cole regarding his allegations, or his recollection of relevant events, before formally charging Dr. Chase with unprofessional conduct when treating him. As Mr. Cole put it, "Nobody really much talked to me." (Cole at 140.) Had the State bothered to take the time to speak with Mr. Cole prior to putting him on the stand, it presumably would not have purposefully elicited Mr. Cole's incorrect testimony that Dr. Maguire and Dr. Cleary told him that he did not have glaucoma or cataracts. Indeed, had the State bothered to talk to Mr. Cole, and to investigate his allegations, it presumably would not have brought charges against Dr. Chase based on his mistaken recollection.

476. At the time he was being treated by Dr. Chase in 1992, Mr. Cole worked for the United States Postal Service during the day, drove a plow on evenings and weekends, and was a volunteer firefighter for the Town of Shelburne. As a plow driver, he was required to drive at night and during snowstorms. (Cole at 91-92.) As a firefighter, Mr. Cole drove heavy equipment, such as trucks and tankers, and was required to do interior firefighting and rescue, operating amid heavy smoke. He performed all of these duties at night and during rain and snow. (Cole at 88-90.) He drove himself to and from his work at the post office, often coming and going in the dark along country roads with no illumination other than vehicle headlights. (Cole at 92-93.)

477. Mr. Cole began seeing Dr. Chase in 1982. At that time, Dr. Chase diagnosed him as being a glaucoma suspect, meaning that he was at higher risk of developing glaucoma. Dr. Chase did not commence any glaucoma treatment, but did take stereoscopic photos of Mr. Cole's optic nerves so that he could monitor the condition of the nerve head over time. (Ex. 501-FC-1-002.)

478. Dr. Chase continued to monitor Mr. Cole for glaucoma. On every visit he performed automated visual fields testing. (Ex. 501-FC-1-033-060; Freeman, 1/8/07 at 21.) On every visit he performed a dilated examination of the back of Mr. Cole's eye, including the optic

nerve head. (Ex. 501-FC-1-001-013.) On every visit, he compared the appearance of Mr. Cole's optic nerve to the baseline photos he had taken in 1982. (*Id.*) On every visit, he measured Mr. Cole's pressures. (*Id.*) He also performed gonioscopy in 1988, examining the trabecular meshwork of Mr. Cole's eyes. (*Id.* at 1-001.)

479. In 1988, Dr. Chase noted increased cupping in Mr. Cole's optic nerve head, the most reliable indicator of glaucoma. (Ex. 501-FC-1-005; Freeman, 1/8/07 at 20.) He took a second set of stereoscopic optic nerve photos. (Ex. 501-FC-1-023.) Dr. Chase also performed gonioscopy on that same date and discovered pigment lodged in his trabecular meshwork, indicating that Mr. Cole was also suffering from pigmentary glaucoma. (Ex. 501-FC-1-001; Freeman, 1/8/07 at 6-7, 22.) On that date, Dr. Chase diagnosed Mr. Cole with glaucoma and began treating him with eye drops. (*Id.*)

480. In 1990, Dr. Chase again noted increased cupping in Mr. Cole's optic nerve head, indicating that his glaucoma was progressing. (Ex. 501-FC-1-010.) Dr. Chase continued to treat Mr. Cole's glaucoma with drops, rather than surgery.

481. In July 1992, Dr. Chase's automated visual fields testing showed that Mr. Cole had a constriction of his visual field, and that he had likely suffered permanent loss of peripheral vision from his glaucoma. (*Compare* Ex. 501-FC-1-033, 034 to 501-FC-1-053, 054; Chase, 9/25/06 at 9-10, 41-43.) Despite Dr. Chase's treatment of Mr. Cole's glaucoma through eye drops, the glaucoma was progressing. (Chase, 9/25/06 at 51.)

482. On July 15, 1992, Dr. Chase also diagnosed Mr. Cole as having nuclear, cortical and posterior subcapsular cataracts. (Ex. 501-FC-1-011; Chase 9/5/06 at 47.) Posterior subcapsular cataracts are particularly likely to cause patients glare disability even as their Snellen visual acuity remains very good. In fact, Dr. Chase testified that the very first cataract he removed during his ophthalmology residency was a posterior subcapsular cataract that did not affect his patient's excellent 20/15 Snellen vision but did cause him glare disability. (Chase, 9/25/06 at 48.)

483. On that same date, Dr. Chase's technician recorded that Frank Cole reported that he was bothered by lights and was fearful when driving at night. (Cole at 122; Ex. 501-FC-1-011.) At the hearing, Mr. Cole admitted to being fearful of not being able to see animals and other objects on the periphery when he was driving. (Cole at 125.) He also to being bothered by

glare when light reflects off of wet roads. (Cole at 125-126.) These complaints correlate perfectly with his cataracts and glaucoma.

484. Mr. Cole's complaints were confirmed by his CST/BAT score of patch two in both eyes, which indicated a significant contrast sensitivity deficit. (Ex. 501-FC-1-028.) His contrast sensitivity was 60% below the bottom of the normal range for his age, and 85% to 90% below the average. (Evans at 208-09.)

485. Dr. Chase offered Mr. Cole combined glaucoma and cataract surgery. (Cole at 127-28.) Combined surgery was the standard of care, both then and now. (Chase, 9/25/06 at 50; Freeman, 1/8/07 at 27.) He did not pressure Mr. Cole into having the surgery. (Cole at 128-29.) Dr. Chase then referred Mr. Cole to his nurse. However, Mr. Cole left Dr. Chase's office instead of seeing the nurse. He said nothing to Dr. Chase that would have led Dr. Chase to believe that he was not going forward with the surgery. (Cole at 130.)

486. Rather than seeing the nurse, Mr. Cole sought a second opinion from Dr. Cleary regarding the proposed cataract/glaucoma surgery. (Chase, 9/25/06 at 52.) Dr. Cleary no longer performs cataract surgery and never performed glaucoma surgery of the type Dr. Chase offered Mr. Cole. (Cleary at 19-20.)

487. Dr. Cleary first examined Mr. Cole on February 25, 1993. (Ex. 501-FC-2-001.) Although it is the standard of care to indicate in a patient's chart whether the examination was performed dilated or undilated, Dr. Cleary's chart does not state that Mr. Cole received a dilated examination on this or any other date. (*Id.*)

488. Dr. Cleary diagnosed Mr. Cole as having cortical cataracts in both eyes. (Ex. 501-FC-1-001.) She measured the cup-to-disc ratio of his optic nerves—which can indicate how much optic nerve death has occurred due to glaucoma—to be .3 in the right eye and .35 in the left. Although she was examining Mr. Cole for the presence of glaucoma on February 25, 1993, Dr. Cleary did not compare Mr. Cole's optic nerve to the photographs taken by Dr. Chase on two prior occasions. She did not perform gonioscopy on Mr. Cole. She did not perform automated visual fields on Mr. Cole. (Ex. 501-FC-2-001-027.)

489. Over the next 13 years, Dr. Cleary continued to examine Mr. Cole regularly. Despite the fact that he had previously been diagnosed with and treated for glaucoma, and despite the fact that he had been diagnosed by Dr. Chase and Dr. Cleary with cataracts, according to her records Dr. Cleary: (1) performed only one more dilated examination of Mr.

Cole, (Cleary at 87, 101); (2) never performed gonioscopy on Mr. Cole, (Cleary at 109); (3) never took optic nerve photographs of Mr. Cole, (Cleary at 106); (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, (Cleary at 79, 107, 110); and (5) only sporadically performed automated visual fields tests on Mr. Cole. (Ex. 501-FC-2-001-027.)

490. Dr. Cleary never recorded any reason not to dilate Mr. Cole. (Cleary at 112.)

491. Dr. Cleary never performed contrast sensitivity or glare testing on Mr. Cole. (Cleary at 85.)

492. Despite having performed none of these tests or examinations, Dr. Cleary stopped treating Mr. Cole for glaucoma in 1994. (Ex. 501-FC-2-002.)

493. The few automated visual field tests performed by Dr. Cleary in subsequent years indicate that Mr. Cole continued to lose vision in the periphery and in the center of his vision during the same period that she was not treating his glaucoma. (Ex. 501-FC-2-020, 021; Freeman, 1/8/07 at 32.)

494. When, at Dr. Cleary's request, Dr. Maguire examined Mr. Cole for central serous retinopathy on April 10, 1995, Dr. Maguire did perform a dilated examination of Mr. Cole's eyes, including his optic nerve heads. She found that his cup-to-disc ratio had grown to .5 in the right eye and .6 in the left eye. (Ex. 501-FC-2-032.) This indicates that Mr. Cole had experienced significant optic nerve death, and accompanying vision loss, since Dr. Cleary measured the same ratios as .3 and .35 in February 1993 but discontinued his treatment for glaucoma. (Freeman, 1/8/07 at 7-8, 30-31.)

495. Dr. Maguire also conducted a dilated slit lamp examination of Mr. Cole's lenses, which revealed nuclear, cortical, and posterior subcapsular cataracts in both eyes, just as Dr. Chase had found three years earlier. (*Compare* Ex. 501-FC-2-032 to 501-FC-1-011.)

496. When Mr. Cole returned to Dr. Cleary from Dr. Maguire for his regular eye care, from 1995 through 2005 Dr. Cleary never dilated him, never diagnosed him as having glaucoma or glaucoma-related visual field loss, never noted the presence of his cataracts again, and offered him no treatment for either disease. (Ex. 501-FC-2-001-027; Cleary at 97.)

497. Dr. Chase provided Mr. Cole with comprehensive glaucoma evaluation and care. (Freeman, 1/8/07 at 33.) Dr. Cleary's examination and care of Mr. Cole fell below the standards set forth in the American Academy of Ophthalmology's Preferred Practice Pattern for glaucoma.

498. Nothing in Dr. Cleary's examination, or lack thereof, calls into question Dr. Chase's decision to offer Mr. Cole combined glaucoma and cataract surgery. To the contrary, the undisputed evidence shows that Mr. Cole has likely suffered permanent vision loss by leaving his glaucoma untreated, and that Dr. Chase acted professionally in recommending surgery to Mr. Cole. (Freeman, 1/8/07 at 37.)

499. Mr. Cole did not file a complaint against Dr. Chase until he read about the State's allegations and the summary suspension in the Burlington Free Press. (Cole at 86-87.)

500. When asked, Mr. Cole refused to have his eyes examined or his vision tested by Dr. Chase' expert ophthalmologist. (Cole at 143; Ex. 671.)

8. Dr. Chase Acted Professionally As To Margaret McGowan (Patient # 11)

501. Margaret McGowan testified on October 3, 2006. Ms. McGowan and her family were patients of Dr. Chase for over 30 years. With the exception of her final examination by Dr. Chase, during which he recommended cataract surgery to her, she felt that she and her family received top quality eye care from him. (McGowan at 128.)

502. Ms. McGowan began receiving eye care from Dr. Chase in 1972. (Ex. 501-MM-1-001; Freeman, 1/8/07 at 63.)

503. Dr. Chase first diagnosed Ms. McGowan with cataracts in 1997. (McGowan at 128; Ex. 501-MM-1-010.) He diagnosed her with cataracts on each subsequent visit in 1999, 2001, and 2003. (McGowan at 128; Ex. 501-MM-1-012, 014, 018.)

504. On each of those occasions, Dr. Chase discussed those cataracts with Ms. McGowan and asked her if she was experiencing any problems driving at night. (McGowan at 128.) On each of those occasions, Ms. McGowan reported to Dr. Chase that she was seeing "starbursts" around oncoming headlights when driving at night. (McGowan at 128.) On each occasion, she told Dr. Chase that the starbursts "bothered her" when driving at night. (McGowan at 134.) These are typical cataract symptoms. (Freeman, 1/8/07 at 64.)

505. Throughout this period, Ms. McGowan was driving at night regularly. (McGowan at 137.)

506. 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 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." (McGowan at 140.)

507. In 1997, 1999, and 2001, Ms. McGowan told Dr. Chase that she was not yet ready for surgery, and Dr. Chase said simply scheduled her for another appointment in two years, saying "When it bothers you enough, we'll take care of it." (McGowan at 140.) On each occasion, Dr. Chase respected her decision not to have surgery. (McGowan 142-43.)

508. 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." (Ex. 501-MM-1-027.) On that same form, she indicated that she would "like more information about" "cataract surgery." (*Id.*) When filling out this same form two years earlier in 2001, Ms. McGowan had not indicated that she was bothered by glare or that she wanted more information about cataract surgery. (Ex. 501-MM-1-029.)

509. 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. (Ex. 501-MM-1-040.) She also reported that she was sometimes "bothered by" poor night vision, glare, hazy or blurry vision, and seeing in poor or dim light. (*Id.*) Finally, she reported that problems with her sight always caused her to be "fearful" when she drove during evening or night hours. (*Id.*; McGowan at 152.) These symptoms, too, are consistent with cataracts. (Freeman, 1/8/07 at 65.)

510. In June 2003, Ms. McGowan's CST/BAT scores, which showed that she scored patch 1 and 2 on the 6 c/d row of the VectorVision test, confirmed her symptoms. (Ex. 501-MM-1-073.) Moreover, those CST/BAT scores had dropped since her 1999 and 2001 examinations. (Ex. 501-MM-1-073, 074.) Her contrast sensitivity was 73% below the bottom of the normal range for her age and 85% to 90% below the average. (Evans at 208-09.)

511. Ms. McGowan testified that in 2003 her CST with BAT was performed only after her eyes were dilated and that Dr. Chase himself performed the test. (McGowan at 163-64.) The State has not alleged in its Amended Superseding Specification of Charges that Ms. McGowan's CST/BAT was performed in a dilated state. Nor does the evidence support such a conclusion. First, Ms. McGowan's chart contains only one CST/BAT slip from her June 13, 2003 examination; all of the evidence demonstrates that CST/BAT was first performed prior to dilation and that if a second test was done after dilation, two test slips appear in the chart. (*See,*

e.g., Ex. 501-SL1-1-071 and 072.) Second, Ms. McGowan's CST/BAT slip is initialed by Amy Landry, demonstrating that Dr. Chase did not perform the test himself; Ms. McGowan testified on cross examination that she has no reason to believe than anyone other than Amy Landry administered her CST/BAT in 2003. (Ex. 501-MM-1-073, Ex. 760, List of Staff Signatures; McGowan at 169.) Third, Ms. McGowan testified on cross examination that, in fact, she did not know whether the various eye drops she was given during her examination with Dr. Chase were for the purpose of dilating her eyes, rather than for some other legitimate diagnostic purpose, such as numbing her eyes in order to measure her pressures or placing dye in her eyes to see how well it cleared. (McGowan at 171-73 ("I have no idea what the drops are.")) Fourth, Dr. Chase testified that Ms. McGowan's CST/BAT was performed exactly the same on every visit and were always performed before her eyes were dilated. (Chase, 9/25/06 at 116.)

512. Dr. Chase reasonably determined that there was no cause for Ms. McGowan's complaint other than her cataracts including her glasses prescription. (Chase, 9/25/06 at 122; Freeman, 1/8/07 at 66.)

513. 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. (McGowan at 155-56.) She felt that it was thorough and, in fact, emphasized all of the risks associated with the surgery. (McGowan at 158.)

514. 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. (McGowan at 154-58.)

515. Dr. Chase accurately informed Ms. McGowan that he had achieved a special level of certification in cataract surgery, but did not tell her that only he could perform the surgery. (McGowan at 180.)

516. Ms. McGowan decided that her vision was bad enough for her to go through surgery. (McGowan at 158.) She had cataract surgery on her right eye on July 1, 2003 and scheduled surgery on her left eye for July 22, 2003. (Ex. 501-MM-1-020.)

517. Dr. Chase's license was suspended before Ms. McGowan was able to have surgery on her second eye. The suspension also interrupted Ms. McGowan's follow-up care regarding her right eye cataract surgery.

518. As a result, Ms. McGowan received an examination from Dr. Tabin for follow up on her operated eye on August 5, 2003. Dr. Tabin informed Ms. McGowan that she had received well performed and successful cataract surgery on her right eye and diagnosed her as having a nuclear sclerotic cataract in her left, unoperated eye. (McGowan at 182-83; Ex. 501-MM-2-020.) Dr. Tabin offered her no opinion on whether her right eye surgery had been appropriate or not.

519. Ms. McGowan reported none of her visual symptoms to Dr. Tabin during the course of his examination. (McGowan at 184.) As a result, he did not offer her cataract surgery on her left eye.

520. Although she had received no medical opinion that her right eye surgery had been inappropriate, Ms. McGowan filed a lawsuit against Dr. Chase, seeking money damages for her “unnecessary” right eye cataract surgery. (McGowan at 121-22.)

521. The Medical Practice Board’s investigator, Phil Ciotti, directed Ms. McGowan to receive another examination by Dr. Morhun, in New Hampshire. Ms. McGowan saw Dr. Morhun on October 21, 2003.

522. When Dr. Morhun asked Ms. McGowan if she was experiencing any visual problems she told him: “I see fine.” (McGowan at 196.) She did not report any of the myriad symptoms she reported to Dr. Chase and his staff, including difficulty with night driving. (McGowan at 196.) After asking Ms. McGowan if she was experiencing any symptoms, Dr. Morhun recorded in his chart: “My ADL’s [activities of daily living] are not affected.” (Ex. 501-MM-2-001.) He acknowledged at the hearing that, although this phrase was recorded in the first person, it was likely his paraphrase of what Ms. McGowan told him, rather than a direct quote. (Morhun at 239-40.)

523. Dr. Morhun diagnosed Ms. McGowan as having a posterior subcapsular cataract in her left eye. This type of cataract can be particularly visually disturbing to patients, even in its earliest stages. (Ex. 501-MM-2-003; Morhun at 237.) He did not notice or record the nuclear cataract that Dr. Tabin noted in his chart. Dr. Morhun formed no opinion, and offered no opinion, on the medical appropriateness of the surgery performed on Ms. McGowan’s right eye. (Morhun at 236.)

524. Dr. Morhun did not perform CST on Ms. McGowan. (Ex. 501-MM-2-001-008.)

525. Although Ms. McGowan had a posterior subcapsular cataract, Dr. Morhun did not recommend surgery because she was not reporting any symptoms. (Morhun at 243.) If Ms. McGowan had reported to Dr. Morhun the same symptoms that she had reported to Dr. Chase, (*see* Ex. 501-MM-1-040), his recommendation regarding surgery “may well have been” different. (Morhun at 244.)

526. If Ms. McGowan had not reported any symptoms to Dr. Chase, he would not have performed surgery on her. (Chase, 9/25/06 at 136.) In fact, in 1997, 1999, and 2001, Dr. Chase did not perform surgery on Ms. McGowan despite the fact that she reported visual symptoms; instead, he respected her evaluation that her symptoms were not yet bad enough to justify surgery. (*Id.*)

527. Ms. McGowan was examined by Dr. Irwin on June 21, 2005. He diagnosed her as having cortical and nuclear cataracts in her left eye. (Ex. 501-MM-2-019.) He did not notice or record the posterior subcapsular cataract that Dr. Morhun’s examination revealed.

528. Neither the State nor the Board’s investigator ever bothered to have Ms. McGowan review the accuracy of the State’s allegations against Dr. Chase before charging him with unprofessional conduct in treating her. (McGowan at 214.)

9. Dr. Chase Acted Professionally As To Joseph Touchette (Patient #12)

529. Joseph Touchette testified on October 2, 2006. He is an engineer who retired from IBM in 2003 and now works as a project management consultant. He has a Master’s degree in structural engineering and has received management training at UCLA, among other institutions. Mr. Touchette’s wife is an LPN with a Master’s degree in health care administration who worked in administration at a hospital. (Touchette at 142, 150-52.)

530. Mr. Touchette began seeing Dr. Chase for his eye care in 1978, when he received his first pair of glasses in order to remedy problems with his near vision. (Touchette at 156; Ex. 501-JT-1-001.)

531. Mr. Touchette was examined by Dr. Chase regularly from 1988 through 1998. On each of his six complete examinations, Mr. Touchette complained of increasing difficulty with near vision, including reading and working on the computer. (Ex. 501-JT-1-003-008; Touchette at 160.)

532. Because Mr. Touchette's job required him to read and work on the computer every day, his ability to perform these tasks comfortably was integral to his ability to perform his job. (Touchette at 191.)

533. Dr. Chase prescribed Mr. Touchette his first pair of bifocals in 1988 in order to address his problems with near vision. Bifocals contain a distance prescription on the top, which addresses distance vision, and a reading prescription on the bottom, which addresses near vision. At the end of each examination between 1988 and 1997, when Mr. Touchette complained of near vision problems, Dr. Chase prescribed Mr. Touchette a stronger reading prescription for his bifocals. On each occasion, the new bifocals would serve Mr. Touchette's needs for a period of years, at which point he would need to have his bifocal prescription strengthened in order to maintain good near vision. (Touchette at 157-160; Ex. 501-JT-1-003-007.)

534. During his April 2, 1997 examination, Mr. Touchette again complained of decreased near vision. (Ex. 501-JT-1-006.) His last bifocal prescription had lasted him over two years. (*Id.*) Dr. Chase first diagnosed Mr. Touchette with nuclear and cortical cataracts in both eyes on that date. (Ex. 501-JT-1-007.) However, Dr. Chase did not propose cataract surgery to Mr. Touchette. Instead, he simply prescribed him another stronger reading prescription for his bifocals, as he had done before. (Ex. 501-JT-1-006-007; Touchette at 155.)

535. At his June 16, 1998 examination, Mr. Touchette told Dr. Chase's technician that he was having difficulty reading the computer screen, trouble with intermediate and near vision, and that he had to work to see things clearly. (Touchette at 159-60; Ex. 501-JT-1-008.) The technician accurately recorded all of Mr. Touchette's symptoms, transcribing the last of these complaints verbatim in Mr. Touchette's chart by placing quotation marks around them. (Touchette at 159-60; Ex. 501-JT-1-008.) Mr. Touchette confirmed that the phrase written in the chart in quotations—"has to work to see things clearly"—was "exactly" what he told the technician. (Touchette at 160.)

536. At his June 16, 1998 examination, Mr. Touchette's prior reading prescription was barely one year old. (Ex. 501-JT-1-006, 008.)

537. On June 16, 1998, Dr. Chase and his technicians refracted Mr. Touchette in order to determine his best distance and near vision, as they had on every visit. (Ex. 501-JT-1-008.) That refraction demonstrated that, for the first time since he began having near vision problems, a new reading prescription would not provide him with any better vision, particularly in his right

eye, where there was no change in his prescription whatsoever. (Ex. 501-JT-1-008; Chase, 9/25/06 at 145-46.)

538. Mr. Touchette's CST/BAT vision, when measured with his best possible glasses prescription prior to dilation, was well below normal for his age and indicated a contrast sensitivity deficit that the FDA would deem a safety problem in night driving situations. (Ex. 501-JT-1-018.) Specifically, his contrast sensitivity was 60% below the bottom of the normal range for his age and 85% to 90% below the average. (Evans at 208-09.)

539. As a result, Dr. Chase correctly concluded that Mr. Touchette's vision complaints were not due to improper glasses and that a new prescription would not remedy Mr. Touchette's near vision problems, particularly in his right eye.

540. Dr. Chase again diagnosed Mr. Touchette as having cataracts in both eyes, with the right eye having a more significant cataract than the left. (Ex. 501-JT-1-009.)

541. Dr. Chase's examination revealed no cause for Mr. Touchette's decreased vision or his significant contrast sensitivity deficit other than his cataracts. (Freeman, 1/8/07 at 58.)

542. Dr. Chase offered to perform cataract surgery on Mr. Touchette's right eye and indicated that he could "consider" left eye surgery "if and when [he was] ready." (Ex. 501-JT-1-009 (emphasis in original).)

543. Dr. Chase's surgery recommendation was reasonable. (Freeman, 1/8/07 at 58.)

544. Dr. Chase referred Mr. Touchette to his nurse for preoperative counseling, education, and informed consent regarding cataract surgery. (Touchette at 169-72.)

545. Mr. Touchette was mistaken in assuming that Dr. Chase was simply referring him to a scheduler, rather than to the nurse who was to provide him with a full informed consent presentation. Mr. Touchette described the "scheduler" as sitting right outside of Dr. Chase's office; no such scheduler existed in Dr. Chase's office. (Touchette at 172-73.)

546. Mr. Touchette understood that it was his choice to proceed with cataract surgery or not. (Touchette at 170.) He did not tell Dr. Chase that he did not want cataract surgery; he did not tell Dr. Chase that he was not going to see the nurse. As Mr. Touchette put it: "As far as he knew, I was going to see the scheduling nurse." (Touchette at 184.) But after leaving Dr. Chase's examination lane, Mr. Touchette instead paid his bill and left the office without telling Dr. Chase of his intention not to schedule surgery. (Touchette at 170-71, 179-81, 184.)

547. Dr. Chase's notation in Mr. Touchette's chart that he "wants cataract removed" accurately represented Dr. Chase's reasonable understanding of Mr. Touchette's intention when last Dr. Chase saw him. (Ex. 501-JT-1-008.) Dr. Chase's chart also accurately reflects that Mr. Touchette ultimately decided against having surgery, noting, "patient decided against surgery." (Ex. 501-JT-1-009.)

548. Because Mr. Touchette declined to meet with the nurse, he did not know that the surgery that Dr. Chase proposed was elective and could be scheduled whenever he felt ready, he did not yet understand the outpatient nature of the procedure, or the details of the operation, and he did not know that he should have the operation only if he felt his poor vision warranted it. If he had visited the nurse and learned these facts, as Dr. Chase suggested, it would likely have allayed his primary concerns about Dr. Chase's recommendation of cataract surgery. (Touchette at 179-83.)

549. 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. (Touchette at 159-60.) He testified that he used the computer nearly every day for work. (Touchette at 191.) Reading the computer screen implicates a patient's contrast sensitivity and glare vision "very much." (Chase, 9/25/06 at 144.)

550. 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." (Ex. 503B at 10.) 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.

551. Mr. Touchette was examined by Dr. James Watson three months later, on September 28, 1998. (Ex. 501-JT-2-001.) Dr. Watson has not performed cataract surgery since 1996. (Watson at 119.)

552. Mr. Touchette told Dr. Watson, as he had told Dr. Chase, that he was having trouble reading his computer screen. (*Id.*; Touchette at 186.)

553. Dr. Watson did not perform CST or glare testing on Mr. Touchette. (Ex. 501-JT-2-002.)

554. Dr. Watson diagnosed Mr. Touchette as having nuclear and cortical cataracts in both eyes, just as Dr. Chase had. (Ex. 501-JT-2-002.) Dr. Watson, too, measured virtually no change in Mr. Touchette's glasses prescription, particularly in his right eye. (*Id.*; Freeman, 1/8/07 at 60.) He identified no other pathology that would account for Mr. Touchette's vision problems. (Freeman, 1/8/07 at 60.)

555. Rather, Dr. Watson admitted that Mr. Touchette's nuclear cataracts were the cause of his vision problems. (Watson at 128.)

556. Dr. Watson did not offer Mr. Touchette cataract surgery, but instead sold him a new pair of glasses, even though the prescription had barely changed, particularly in the right eye. (Ex. 501-JT-2-002.)

557. Unsurprisingly, when Mr. Touchette next visited Dr. Watson, he was experiencing the same problems reading his computer screen. (Ex. 501-JT-2-003.)

558. Dr. Watson noted that Mr. Touchette's nuclear cataracts had advanced since his last visit. (Freeman, 1/8/07 at 62.) Although Mr. Touchette's problems reading the computer screen and the printed page occupied nearly 70% of Mr. Touchette's working time, Dr. Watson did not offer him cataract surgery; in fact, they did not talk about his cataracts at all. (Touchette at 192-93.) Dr. Watson determined on his own that Mr. Touchette's cataract was not "significant" enough to warrant removal. (Watson at 117.)

559. On his last visit to Dr. Watson, Mr. Touchette again complained of trouble reading the computer screen, again had cataracts, and was again given new glasses. (Watson at 118.)

560. It was Dr. Watson's belief that he could "keep up" with Mr. Touchette's cataracts "for quite a few years" "by changing glasses a lot of the time." (Watson at 114-15.) However, there was no appreciable change in Mr. Touchette's glasses prescription, particularly in his right eye, on any of the occasions Dr. Watson examined him. Mr. Touchette kept returning with the same symptoms year after year, despite his new glasses. Moreover, unlike Dr. Chase, Dr. Watson never evaluated Mr. Touchette's contrast sensitivity or glare vision. Dr. Chase's evaluation determined that Mr. Touchette had a significant contrast sensitivity deficit, even with his very best corrected vision. As a result, no glasses could correct for that deficit. (Freeman, 1/8/07 at 58-61.)

561. In sum, Mr. Touchette came to Dr. Watson complaining of problems reading the computer screen; Dr. Watson prescribed new glasses; Mr. Touchette came back still complaining of trouble reading the computer screen, and Dr. Watson again prescribed new glasses; Mr. Touchette came back a third time, still complaining of trouble reading the computer screen, and Dr. Watson, who has not performed cataract surgery since 1996, again recommended new glasses. (Watson at 118-19, 200-01.)

562. Mr. Touchette did not file a complaint with the Board until after he had read about Dr. Chase's license suspension in the newspaper. (Touchette at 197.) After he filed his complaint, neither the Board's investigator nor the State bothered to interview Mr. Touchette or speak with him about his complaint. Instead, they simply relied upon his written complaint in bringing charges against Dr. Chase.

10. Dr. Chase Acted Professionally As To William Augood Pierson (Patient # 13)

563. William Augood Pierson testified on October 24, 2006. He is referred to in the medical records, and throughout these proposed findings, as William Augood. However, since being treated by Dr. Chase, he has married and taken his wife's name, and is therefore sometimes identified in the record as William Augood Pierson.

564. Mr. Augood was examined by Dr. Chase on one occasion on October 30, 2002. Mr. Augood met with a technician and filled out his own history form before he ever spoke with Dr. Chase. When the technician took his history, he told her that he was having some trouble with glare on bright days. (Ex. 501-WA-1-001.) When filling out his own Eye Health History form, Mr. Augood indicated that he was currently "bothered by glare." (Ex. 501-WA-1-007.) He confirmed these symptoms when testifying under oath at the merits hearing. (Augood at 60-62.)

565. Dr. Augood was first seen by Dr. Devita, an optometrist who worked in Dr. Chase's office at the time. Dr. DeVita did an initial examination of Mr. Augood's eyes and asked him what he was doing to manage his cataracts. (Augood at 87-88.)

566. Dr. Chase then examined Mr. Augood and diagnosed him as having cataracts in both eyes. Dr. Chase drew a picture of Mr. Augood's cataracts in his medical chart; the type of cataracts that Mr. Augood has are commonly associated with glare problems. (Ex. 501-WA-1-001, 002; Chase, 9/26/06 at 14-15.)

567. Dr. Chase measured Mr. Augood's Snellen vision as 20/40 in both eyes. (Ex. 501-WA-1-009; Chase, 9/26/06 at 18.) His CST/BAT score, measured with his best corrected visual acuity prior to dilation by the technician, was patch 2 and patch 3 on the 6 c/d column of the VectorVision test, 60% below the bottom of the normal range and 85% to 90% below the average. (Evans at 208-09.) Mr. Augood's CST/BAT score was worse in his right eye than in his left. (Chase, 9/26/06 at 19-20.)

568. Multiple refractions performed by Dr. Chase and his technicians revealed that there was absolutely no change in Mr. Augood's prescription for his right eye. (Ex. 501-1-WA-001) In addition, problems with glare are rarely corrected through glasses change.

569. Dr. Chase's examination revealed no other cause other than cataracts for Mr. Augood's symptoms, his low Snellen score, or his CST/BAT deficit. (Chase, 9/26/06 at 21-25.) He also identified no treatment other than cataract surgery that was likely to address Mr. Augood's symptoms. (*Id.*)

570. At the conclusion of his examination, Dr. Chase asked Mr. Augood if he wanted to hear about cataract surgery, and he said "no." Dr. Chase did not discuss the topic of surgery further at that time. However, as he was about to leave, Mr. Augood asked Dr. Chase what he could do about his glare symptoms, Dr. Chase informed him that new glasses would not help his symptoms, and again asked Mr. Augood if he wanted to hear about cataract surgery. Mr. Augood indicated that he did. (Augood at 88-91; Chase 9/26/06 at 9.)

571. Dr. Chase would not have offered Mr. Augood cataract surgery if he had not complained of problems with glare. (Chase, 9/26/06 at 28-29.)

572. Mr. Augood confirmed that Dr. Chase simply "offered" to perform cataract surgery on Mr. Augood's right eye. (Augood at 91-92; Ex. 501-WA-1-002.) He then spent time telling him about cataracts and cataract surgery. (Augood at 97.) He then told Mr. Augood that he could go see the nurse to schedule the surgery. (Augood at 98.) Mr. Augood then left Dr. Chase's examination lane.

573. However, instead of going to see the nurse, Mr. Augood paid his bill and left Dr. Chase's office without telling Dr. Chase that he was not going to see the nurse and was not going to schedule cataract surgery. (Augood at 98.)

574. Nothing that Dr. Chase said to Mr. Augood about second opinions had the effect of discouraging Mr. Augood from getting a second opinion. (Augood at 92; Chase, 9/26/06 at 23.)

575. Indeed, Mr. Augood sought and received a second opinion from an optometrist, Dr. Dora Sudarsky, one week later on November 6, 2002. (Ex. 501-WA- 2-013.) Dr. Sudarsky agreed entirely with the refraction that Dr. Chase and his technicians had performed on Mr. Augood, as well as the resulting glasses prescription. She, too, could not improve the vision in Mr. Augood's right eye beyond 20/30, regardless of the prescription used. Dr. Sudarsky also diagnosed Mr. Augood as having cataracts in both eyes, with the right being worse than the left. (Ex. 501-WA-2-014.) She informed him that his cataracts looked like a spidery web of wispy veins that was already fairly spread out across the front of his eye. (Augood at 42.) She told him that the type of cataract that he had made people more susceptible to glare than other types of cataracts. (Augood at 37.) She also told him that if his symptoms were bothering him at that time, cataract surgery would be an appropriate treatment. (Augood at 44-46; Ex. 655, Augood Federal Trial Transcript.) She said that he should have surgery when he felt he was being bothered by his cataracts. (Augood at 58.)

576. Although he had twice told Dr. Chase and his technicians that he was being bothered by glare, when filling out Dr. Sudarsky's history form just one week later, he answered "no" to the question: "Do you have trouble with glare?" (Ex. 501-WA-2-013.) As a result, and because Mr. Augood did not report any other symptoms to her, Dr. Sudarsky did not recommend cataract surgery for Mr. Augood at that time.

577. Mr. Augood was examined by Dr. Thomas Cavin nearly a year later on October 6, 2003. (Ex. 501-WA-2-002.) Dr. Cavin diagnosed Mr. Augood as having a type of cataract that made him particularly susceptible to glare problems. (Cavin at 240-41.) However, Mr. Augood told Dr. Cavin's technicians that he was experiencing no limitations in his vision. (Ex. 501-WA-2-002; Cavin at 242.) Although Mr. Augood complained to Dr. Cavin's technician of "some difficulty driving at night due to glare," Dr. Cavin interpreted this to mean that the glare Mr. Augood was experiencing was nothing more than a nuisance, rather than a problem. (Cavin at 243-44.) As a result, Dr. Cavin did not perform any glare testing, much less any contrast sensitivity testing, on Mr. Augood. (Cavin at 244-45.)

578. If Mr. Augood had complained to Dr. Cavin, as he had to Dr. Chase, that he was actually having trouble with glare on bright days and was “bothered” by glare, Dr. Cavin would have performed glare testing and may have offered him cataract surgery if the testing corroborated Mr. Augood’s symptoms. (Cavin at 245-47.)

579. Dr. Cavin’s technicians never performed a manual refraction of Mr. Augood and therefore never measured his best corrected visual acuity. (Chase, 9/26/06 at 28; Ex. 501-WA-2-003; Cavin at 230.)

580. Dr. Cavin’s examination revealed nothing other than Mr. Augood’s cataracts that would account for his symptoms of glare and reduced visual acuity. (Cavin at 247-48.)

581. Mr. Augood did not file a complaint against Dr. Chase until after he read about the summary suspension in the newspaper.

582. Mr. Augood admitted numerous times during his testimony that his memory of relevant events was not good. (*See, e.g.*, Augood at 61-62, 69 (“I’m not remembering well.”), 84 (“I don’t remember very well.”), 85 (“I don’t remember that detail.”), 89 (“I honestly don’t remember the details. . . . I honestly don’t remember what [Dr. Chase] told me.”), 90 (“I just don’t remember what I said.”), 119.)

583. He 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. (*See, e.g.*, Augood at 34-41, 44-48, 61-62.)

584. He was easily distracted during his testimony at the merits hearing, complaining that Dr. Chase’s counsel was “fidgeting” and thereby preventing him from testifying.

585. Prior to charging Dr. Chase with unprofessional conduct based on Mr. Augood’s allegations, neither the Board’s investigator nor the State contacted him to discuss the substance of his allegations or to retrieve his notes of his examination by Dr. Sudarsky, in which she said that he had significant cataracts that would justify surgery whenever he was experiencing symptoms. Instead, he was effectively told by the State: “don’t call us, we’ll call you.” (Augood at 106-07.)

11. Dr. Chase Acted Professionally As To Jan Kerr (Patient # 14)

586. Jan Kerr testified on October 3, 2006. Dr. Chase examined Ms. Kerr once, on November 20, 2002. (Ex. 501-JK-1-001.)

587. In November, 2002, Jan Kerr was 52 years old, lived in Hinesburg, Vermont, and was employed as an operating room nurse at Fletcher Allen Health Care. (Kerr at 6-8.)

588. Ms. Kerr needed to and did drive 11 miles from her home to FAHC, worked different shifts at the hospital, and frequently had to drive in the dark and in widely varying weather conditions. (Kerr at 23.)

589. Ms. Kerr wore contact lenses to correct her vision; her vision was “constantly changing” and she needed regular changes in her lens prescription. (Kerr at 21-22.)

590. In 2002, she noticed a decline in her vision, both near and far, and as a result she made an appointment to see Dr. Chase on November 20, 2002. (Kerr at 24-25.)

591. At her November 20, 2002 examination, Ms. Kerr reported that she noticed a decrease in both her near and far vision, (Kerr at 25-26), 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), (Kerr at 16-17), and was having difficulty seeing to drive at night because of glare. (Kerr at 32-33.) She believes that she informed Dr. Chase of all of these problems and the medical records kept by Dr. Chase’s office reflect this. (Kerr at 27-29, 32-33 and Ex. 501-JK-1-001, 008.)

592. A couple of years prior to having her eyes examined by Dr. Chase, Ms. Kerr had been involved in a serious automobile accident when sun glare prevented her from seeing a stop light and she collided with another vehicle in the intersection after failing to stop at the signal. (Kerr at 25-26.)

593. Ms. Kerr underwent extensive testing at Dr. Chase’s office in several different exam rooms, and she feels that Dr. Chase gave her a very thorough exam. (Kerr at 29.)

594. Dr. Chase’s medical records show that Jan Kerr received contrast sensitivity with glare testing both before and after dilation and each time she scored a patch 1 and patch 2 (which have a Snellen equivalency score of 20/100 and 20/70). (Ex. 501-JK-1-010, 011.) On the CST test slip (located on the top left inside of record jacket) it clearly indicates that her Snellen visual score in both eyes was 20/30. (Ex. 501-JK-1-011.) On the eye examination chart, (Ex. 501-JK-1-001), in the section marked “V vision”, the scores 20/100; 20/70 and 20/30; 20/30 both appear, and immediately below them is the score 20/100; 20/70 and it is expressly noted as being “CSTw/BAT.” (Ex. 501-JK-1-001.) Ms. Kerr’s contrast sensitivity was 73% below the bottom of the normal range for her age and 85% to 90% below the average. (Evans at 208-09.)

595. As Dr. Chase was performing his slit lamp examination, Ms. Kerr heard him describe what he was seeing to the scribe as “opaque”, which she suspected, given her training and experience as a nurse, indicated she had cataracts. Accordingly, at the conclusion of the slit lamp examination, Ms. Kerr asked Dr. Chase about the word opaque. (Kerr at 34.)

596. Dr. Chase informed Ms. Kerr that she did indeed have cataracts which was a shock and unpleasant surprise to her. (Kerr at 35.) She does not recall specifically what Dr. Chase said about cataract surgery other than that her cataracts were significant enough to warrant surgery. (Kerr at 35, 78-80.)

597. Dr. Chase did explain the risks and benefits of cataract surgery to Ms. Kerr. (Kerr at 35-36.) When she asked him about a second opinion, Ms. Kerr recalls that he told her that he was the only ophthalmologist in the area who had received a particular certification from a “particular organization.” (Kerr at 36-37.) Ms Kerr was not paying much attention to what Dr. Chase said about the certification because she was worried about the cataracts and what she was going to do about them. (Kerr at 37.) Dr. Chase knew that Ms. Kerr was an OR nurse because she had informed him of that fact. (Kerr at 39-40.)

598. Dr. Chase suggested Jan Kerr visit with the scheduling nurse, and she did in fact meet and talk with the nurse without informing Dr. Chase that she did not want surgery. (Kerr at 38-43.) Dr. Chase’s nurse was polite and courteous and gave her written explanatory information regarding cataract surgery to take home with her. (Kerr at 38-41.)

599. During the meeting with Dr. Chase’s nurse, Ms. Kerr said she wanted to defer making any decision about cataract surgery until after she had an opportunity to speak to her husband, who had previously had cataract surgery from Dr. Chase with a very successful outcome. (Kerr at 13.) Ms. Kerr agrees that Dr. Chase’s medical records accurately reflect what she told the nurse regarding deferring the surgery decision. (Kerr at 44-45; Ex. 501-JK-1-002.)

600. Although Dr. Chase, based on his interaction with Ms. Kerr, noted on the chart that she wanted cataract surgery, the record for her exam clearly states Ms. Kerr decided to defer surgery. It is not unusual for a patient to change their decision to have surgery after going through the informed consent, procedure, and there was nothing wrong with Dr. Chase’s initial entry. (Freeman, 12/18/06 at 175-77.)

601. Based on information that Jan Kerr received at Dr. Chase’s office, Ms. Kerr had knowledge before leaving Dr. Chase’s office that:

- (a) the decision to have cataract surgery was her decision to make;
- (b) slight blurring in vision could be helped for a while with a new prescription;
- (c) delaying surgery, with few exceptions, will not jeopardize a good result and many people with cataracts are able to see well enough to do what they want to do;
- (d) the decision to have cataract was the patients to make when they concluded that cataract induced vision loss was preventing them from seeing well enough to do what they need to do or enjoy doing. (Kerr at 40-42, 62.)

602. On January 15, 2003, Jan Kerr saw Dr. Irwin for a second opinion regarding her cataracts. Dr. Irwin's medical records indicate that Ms. Kerr reported that the quality of her vision was "poor night, dim light", and that "works in OR—so if lights are turned down a problem." Thereafter it is noted "mild problem." (Ex. 501-JK-2-011.)

603. Dr. Irwin's medical records also reflect that he diagnosed Ms. Kerr with "trace nuclear cataracts and trace cortical cataracts" in both eyes, and that when tested with the BAT on medium,³ Ms. Kerr's vision on the Snellen chart in her right eye declined five lines from 20/20 to 20/60. Dr. Freeman described that result as representing "a very significant decrease" in functional glare vision. (Freeman, 12/18/06 at 178-79.)

604. Although her vision fell 5 lines when subjected to medium glare with the BAT, Dr. Irwin could not determine from his records if Ms. Kerr was asked about problems with glare. (Irwin at 173.) He does not know why the record does not reflect any inquiry with Ms. Kerr regarding glare symptoms. (Irwin at 177-78.)

605. Ms. Kerr remembers complaining about her visual problems during her examination by Dr. Irwin. She does not recall describing her vision problems as being mild, but she did recall that she wanted the problem fixed because she did not want to make a mistake in the OR. (Kerr at 47-48.)

606. There was nothing in Dr. Irwin's records clarifying whether the word "mild" qualified all or less than all of her visual symptoms. (Irwin at 175-76.)

³ The medium setting on the BAT simulates the degree of light that exists outside on a partly cloudy day. Dr. Irwin always used the medium setting on the BAT because he mistakenly believed it simulated the amount of indirect light/glare that a person experiences when outside on a bright sunny day. (Irwin at 123.)

607. Dr. Irwin found no conditions in Ms. Kerr's eyes during his examination other than the cataracts, that explained Ms. Kerr's complaints regarding her visual symptoms. (Irwin at 174.)

608. Dr. Irwin told Ms. Kerr that everyone her age had cataracts like hers, that she did not need surgery and he was not offering her surgery. (Kerr at 49, 55.)

609. Ms. Kerr does not recall Dr. Irwin telling her that her vision in her right eye dropped to 20/60 Snellen under lighting conditions simulating out outdoors on a partly cloudy day. (Kerr at 52.) Dr. Irwin testified that he did not inform Ms. Kerr of her Snellen test score with BAT, because he attaches no significance to it and does the test only to satisfy the paper pushers. (Irwin at 181.) Dr. Freeman testified he would definitely discuss such a significant decrease in glare vision with the patient. (Freeman, 12/18/06 at 179-80.)

610. Jan Kerr would want to know if her vision declined from 20/20 to 20/60 in outdoor lighting and believes that an ophthalmologist should inform the patient of that fact and discuss ways to fix that visual loss. (Kerr at 54-55.)

611. Dr. Irwin then referred Ms. Kerr to Dr. Guilfooy, another ophthalmologist, to receive a new contact lens prescription because Dr. Guilfooy was an expert in prescribing contact lenses. (Kerr at 56.) Ms. Kerr also asked Dr. Guilfooy for a second opinion wither she should have cataract surgery. (Guilfooy at 244.)

612. Dr. Guilfooy did not do a dilated slit lamp exam of Ms. Kerr and believes he may have not taken a complete history of her vision symptoms. (Guilfooy at 234-35.) He explained he limited his exam because Ms. Kerr had received full exams from Dr. Irwin and Dr. Chase in the preceding few months. (*Id.*) His records indicate he did not diagnose Ms. Kerr with cataracts.

613. Ms. Kerr saw Dr. Guilfooy many times in the following months in an attempt to obtain contact lenses with a prescription that would help her vision. (Kerr at 63-68.) She described her vision both then and now as "constantly changing." (Kerr at 21-22.) Finally Ms. Kerr received a prescription from Dr. Guilfooy that helped her to see better, but since then she has had to have her contact lens prescription changed yet again by another doctor. (Kerr at 68-69.) She attributes her frequently changing vision to the aging process. (Kerr at 68.)

614. Even after Ms. Kerr received the corrective lens prescription that gives her the best possible vision, she still has problems with glare while driving at night and still has problems seeing in dim light. (Kerr at 22.)

615. Jan Kerr was very upset with Dr. Chase after Drs. Irwin and Guilfooy said she should not have cataract surgery. (Kerr at 14-15.) After she read in the newspaper that Dr. Chase's license had been suspended, she wrote a letter to the Medical Practice Board in 2003, complaining about his recommendation of surgery to her in November, 2002. (Kerr at 69.)

616. Ms. Kerr received a written request from Dr. Chase's attorney asking that she submit to an independent eye examination, but she refused. (Kerr at 70.)

617. After reviewing the medical records for Jan Kerr from the offices of Drs. Chase, Irwin and Guilfooy, Dr. Freeman testified that in his opinion it was reasonable for Dr. Chase to offer Jan Kerr cataract surgery. (Freeman, 12/18/06 at 179.) As of the date of her hearing testimony, Jan Kerr had never read and was unaware of the contents of the charges the State had filed against Dr. Chase based upon her testimony. (Kerr at 71-72).

X. THE RESPONDENT'S PRACTICE INNOVATIONS IN VERMONT

618. During his 35 years in practice, Dr. Chase strove to learn and incorporate new technology and medical advances into all facets of his ophthalmology practice. To do so he regularly attended CME seminars throughout the country, and amassed four times as many Category I CMEs as required, reviewed medical education tapes in traveling to and from work each day and was a habitual reader of ophthalmology and medical journals. (B. Chase at 180-81; Chase, 9/26/06 at 51-55.)

619. For instance, 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. It was then a controversial procedure; it is now the method by which virtually all modern cataract surgery is performed. (Chase, 9/26/06 at 52.)

620. Dr. Chase was the first doctor in Vermont to implant intraocular lenses ("IOLs") during his cataract surgery after learning how to do it at Green Hospital in San Francisco; although nearly all cataract surgery is now performed using IOLs, their use was highly controversial when Dr. Chase first utilized them. (Chase, 9/26/06 at 54.)

621. Dr. Chase was the first ophthalmologist in Vermont to purchase and use a laser to perform therapeutic and refractive surgery on his patients, a practice now widely recognized as routine. He made it available to all area ophthalmologists. (Tabin at 72.)

622. Dr. Chase was the first and only ophthalmologist in Vermont to perform his surgeries in an ambulatory surgical center (“ASC”) attached to his office, rather than in a hospital setting; in the rest of the country, 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. (Chase, 9/26/06 at 54.)

623. In the early 1990s, Dr. Chase became the first and only ophthalmologist in Vermont to utilize contrast sensitivity testing (“CST”) to evaluate his patients’ vision; the American Academy of Ophthalmology (“AAO”) has since recognized CST to be a “more comprehensive measure of visual function” than traditional Snellen visual acuity. (Chase, 9/11/06 at 122-23; Ex. 503B, AAO PPP at 14.)

XI. DR. CHASE’S QUALITY ASSURANCE PRACTICES

624. 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. (Chase, 9/26/06 at 45-48.)

625. Dr. Chase voluntarily chose to have his ASC certified by AAAHC, an independent reviewer of surgical centers; AAAHC regularly reviewed Dr. Chase’s surgical practices, including his medical charts. (Chase, 9/26/06 at 47.)

626. 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; Dr. Chase was the only ACES certified ophthalmologist in Vermont, and was re-reviewed and recertified regularly until his license was suspended. (Chase, 9/12/06 at 24-25; 9/26/06 at 48-51.)

627. Dr. Chase also set up a Quality Assurance committee, comprised of himself, his office staff, and an outside physician; Dr. Chase invited the medical director of CHP, then the State’s largest insurer, to sit on his Quality Assurance committee. (Chase, 9/26/06 at 47.)

628. The Quality Assurance committee regularly reviewed his cataract surgery charts. (*Id.*) No other physician who testified before the Panel employed such rigorous quality assurance practices.

XII. DR. CHASE RAN HIS PRACTICE WITHOUT REGARD FOR PROFIT

629. In structuring his clinical practice, Dr. Chase routinely placed his patients' well being ahead of his own profit.

630. Dr. Chase employed approximately 12 staff members to help him examine and treat approximately 25-30 patients per day and schedule approximately 250 cataract surgeries per year. (Ex. 760; Chase, 9/12/06 at 70; Freeman, 12/18/06 at 138-42.) In contrast, Dr. Morhun, the State's expert, employs one staff member, who had no clinical responsibilities, in order to schedule approximately 700 cataract surgeries per year. (Morhun at 28-29.) Dr. Cavin, another of the State's experts, employs 4 staff members in order to treat 35-40 patients per day and schedule 400 surgeries per year. (Cavin at 153-154.) Dr. Tabin utilized 1 to 3 staff members in order to examine 30 to 40 patients per day and perform 250 cataract surgeries per year. (Tabin at 39-42.) Many high volume surgeons around the country perform over 4000 cataract surgeries per year. (Tabin at 40.)

* 631. Dr. Chase expended considerable resources in educating his staff by paying for them to attend training seminars throughout the country. (Brienne Chase Federal Trial Testimony at 53.)⁴

* 632. Dr. Chase purchased the first excimer eye laser in Vermont, paying \$250,000 for the machine, even though it would never pay for itself. (*Id.* at 32-34.)

* 633. In the early 1980s, Dr. Chase opened the first and only ophthalmic ambulatory surgery center ("ASC") in Vermont because he was "dedicated to keeping people out of hospitals for as much surgery as you could." (*Id.* at 37.) Although the ASC cost at least \$500,000 to fit up, insurance payment rules did not allow Dr. Chase to charge a so-called "facility fee" for the first 10 years that he used it. During that time, he operated it at his own expense and provided the facility, or supplies and/or nursing support for free. (*Id.* at 38-39.)

634. Unlike any other doctor who testified, 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 those fields; he felt that routine visual fields were the best way to detect early glaucomatous vision change. (Freeman, 12/18/06 at 138-39; Chase, 9/12/06 at 95-97; 9/26/06 at 45.)

⁴ The Respondent proffered the federal trial testimony of Ms. Chase, but the Board excluded most of her testimony at the hearing. The proposed findings based solely on her excluded testimony are designated by an asterisk ("*").

635. Dr. Chase's office performed expensive and time consuming pre-operative tests, such as endothelial cell counts, on every patient; although routine endothelial cell counts are not reimbursed by insurance, Dr. Chase felt they were important for determining the health of the patient's cornea prior to cataract surgery. (Freeman, 12/18/06 at 139-41.)

636. Dr. Chase's office employed a registered nurse to administer his complete informed consent procedure, rather than a less expensive, non-medically trained employee. (Chase, 9/12/06 at 155-56.)

637. 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.*" (Ex. 569 (emphasis added); Chase, 9/26/06 at 55-56.)

* 638. Dr. Chase had absolutely no interest in money or financial matters generally. Nonetheless, through the success of his medical practice and Brianne's investment in Burlington-area real estate, Dr. and Mrs. Chase grew financially comfortable. By the mid-1990s, when Dr. Chase was 60 years old, they were financially secure by any measure. (Brianne Chase Federal Trial Testimony at 74, 94-108.) At that time, Brianne Chase asked her husband to retire, but Dr. Chase loved the practice of medicine too much to quit. (*Id.* at 75.)

639. The only reason any doctor would incorporate these practices into his evaluation of cataract patients "is to be the best doctor he can be." (Javitt at 127.)

XIII. DR. CHASE'S CHAIRSIDE MANNER

640. Dr. Chase's manner of communicating with patients was direct, straightforward and very businesslike in recommending treatment, including surgery, to his patients. He was not talkative or chatty with patients. (Chase, 9/25/2006 at 162; 9/26/06 at 37.)

641. While many patients preferred this and responded well to his businesslike demeanor, some others may have preferred a friendlier, more personalized, emotionally supportive figure. (Chase, 9/26/06 at 39.)

642. Dr. and Brianne Chase recognized his limitations in interacting and communicating with his patients, and took extra care to provide emotional support and comprehensive communications to patients. (Chase, 9/25/2006 at 162-63.)

643. Brianne Chase hired registered nurses to counsel cataract patients regarding surgery in order to make certain that his patients received the full range of communications,

support and information they needed to make informed decisions regarding their healthcare. (Chase, 9/25/06 at 162-63.)

644. Dr. Chase's chairside manner while sometimes businesslike or impersonal, was not unprofessional.

XIV. CONCLUSIONS

645. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally in offering cataract surgery to any of the eleven complaining patients.

646. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally in performing cataract surgery on Ms. Salatino, Ms. Lang, or Ms. McGowan.

647. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not intentionally or actually discourage Ms. Nordstrom, Ms. Lang, Mr. Augood, or Ms. Kerr from seeking a second opinion.

648. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally when his scribes noted "second opinion given" in the charts of Ms. Nordstrom, Ms. Salatino, Ms. Lang, Ms. Grigas, Ms. Corning, Ms. McGowan, Mr. Touchette, Mr. Augood, and Ms. Kerr.

649. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally when he recorded in the patients' medical charts his understanding that Ms. Corning, Mr. Touchette, Mr. Augood, and Ms. Kerr wanted their cataracts removed.

650. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally when he recorded in the patients' medical charts his conclusions that Ms. Lang could not see to drive safely, Ms. Grigas could not see to drive safely due to glare, Mr. Touchette's cataracts interfered with his life, or Ms. Kerr could not see to drive safely.

651. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally when he asked his technicians to re-perform Ms. Lang's CST with BAT after her eyes were dilated and recorded both test results in her chart.

652. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not re-perform Ms. Nordstrom's or Ms. Salatino's CST with BAT after their eyes were dilated and therefore did not act unprofessionally toward them.

653. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not falsify his patients' vision test scores and did not act unprofessionally when he relied on his patients' CST with BAT scores in assessing their functional vision and when he recorded his patients' CST with BAT scores in his patients' charts.

654. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not falsify his patients' charts and did not act unprofessionally when he used the descriptor "dense" to designate the cataracts of Ms. Salatino, Ms. Lang, Ms. Grigas, Ms. Corning, Ms. McGowan, Mr. Touchette, Mr. Augood, or Ms. Kerr.

655. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not falsify Ms. Grigas' chart in recording the date of her scheduled surgery.

656. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally when he did not document that Mr. Olson was offered cataract surgery, because Mr. Olson was not offered cataract surgery.

657. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not attempt to schedule Ms. Corning's cataract surgery for July 4, 2000 and therefore did not act unprofessionally toward her.

658. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally toward Mr. Cole in offering him combined glaucoma and cataract surgery.

659. For the foregoing reasons, and based on all of the record evidence, the Board finds that Dr. Chase did not act unprofessionally toward any of the complaining patients in any manner or at any time.

660. Instead, based on all of the record evidence, the Board finds that Dr. Chase provided all of the complaining patients with high quality ophthalmic care and medically appropriate treatment and recommendations.

661. The Board therefore enters judgment in favor of Dr. Chase on all counts in the Amended Superceding Specification of Charges.

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

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