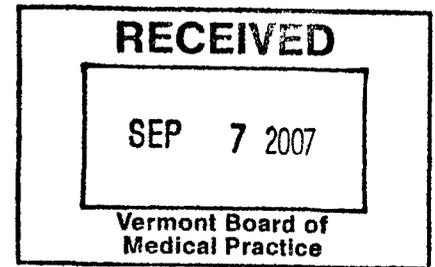


STATE OF VERMONT
BOARD OF MEDICAL PRACTICE



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 EXCEPTIONS TO THE HEARING COMMITTEE REPORT

Respondent, David S. Chase, M.D., hereby submits the following Exceptions to the Hearing Committee Report. In support of his Exceptions, Dr. Chase relies on the following incorporated Memorandum, his Post-Trial Briefs, and his Proposed Findings Of Fact and Conclusions Of Law, all of which are incorporated herein. Dr. Chase respectfully requests that the Board review both parties' Proposed Findings of Fact and Conclusions of Law, their Post-Trial Briefs, and the Committee's Report prior to reviewing his Exceptions, which presume familiarity with the aforementioned documents and the facts set forth therein.

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MEMORANDUM

I. Introduction.

The Hearing Committee Report (the “Report”) exonerates Dr. Chase of all of the State’s central allegations of unprofessional conduct. The Report rejects the State’s claims that Dr. Chase performed unnecessary surgeries. It concludes that Dr. Chase did not recommend cataract surgery that he knew his patients did not need. It finds that he did not purposefully falsify his medical records in order to justify that surgery. As a result, the Report determines that Dr. Chase did not engage in conduct evidencing an unfitness to practice medicine, did not willfully misrepresent treatment or create false records, and did not engage in immoral, unprofessional, or dishonest conduct. The Board should accept these conclusions and reject the State’s primary and most serious allegations.

While the Committee exonerated Dr. Chase of the State’s central and most serious allegations of misconduct, it nonetheless found that Dr. Chase committed violations of 26 V.S.A. §§ 1354(a)(22) and 1354(b) in three different ways when he: (1) described his patients’ cataracts as “dense” in order to convey his conclusion that the cataracts were visually significant; (2) failed to “thoroughly and adequately” discuss his patients’ vision and visual needs with them in a “collaborative” way; and (3) apprised his patients of the elective nature of cataract surgery by informing them that if they received a second opinion, they would likely be told that they did not need cataract surgery if their vision still suited their needs. None of these three conclusions calls into question the propriety of Dr. Chase’s cataract surgery recommendations. Nonetheless, these conclusions are at odds with the evidence and contrary to law.

The Committee’s conclusion that it was unprofessional for Dr. Chase to use the descriptor “dense” to designate visually significant cataracts is contrary to the undisputed

evidence presented by both parties' expert witnesses, the American Academy of Ophthalmology ("AAO"), and the Committee's own proposed findings of fact, which state that there is no requirement, much less a well-defined standard, that physicians must use in describing their patients' cataracts. Dr. Chase's decision to use a descriptor that allowed him to quickly distinguish between visually significant and non-visually significant cataracts was entirely proper, and no one was misled by it.

The Report next concludes that Dr. Chase's methods of communicating with his patients were not sufficiently "thorough," "adequate," or "collaborative," and thereby constitute a gross deviation from the standard of care and a failure to practice competently. This conclusion is legally and factually deficient for a number of reasons. As an initial legal matter, the State's Superseding Specification of Charges does not allege that Dr. Chase's purported failure to adequately communicate with his patients constitutes unprofessional conduct. Instead, the State raised this allegation only after the hearing ended. The Board cannot sanction Dr. Chase for unprofessional conduct with which he is not charged. In addition, at the State's request, Dr. Chase was prevented from presenting the Committee with all of his evidence regarding the extensive patient counseling process that his office performed with respect to every cataract patient. Despite these legal errors, the testimony of the State's own patient and physician witnesses demonstrates that Dr. Chase's patient counseling and informed consent process was not only thorough and adequate, it was second to none.

Finally, the Committee found that Dr. Chase failed to practice competently and engaged in a gross deviation from the standard of care when he provided his patients with a hypothetical second opinion designed to reinforce the elective nature of cataract surgery and recorded that fact in his charts. The Report concludes that, through his presentation, Dr. Chase discouraged his

patients from seeking a second opinion. Once again, the Report recommends sanctioning Dr. Chase for conduct with which he was not charged, and which is contrary to the evidence, including testimony improperly excluded.

The Committee also declined to perform a searching inquiry of each patient's credibility, recommending that the Board adopt the same rote endorsement of each patient's ability to accurately recall the details of his or her examination. That failure is particularly important in light of the fact that Dr. Chase is understandably unable to recall the details of his interactions with 11 of the many thousands of cataract patients he examined in the decade between 1992 and 2003. The Board should re-evaluate each patient's credibility on the record evidence before crediting the patients' assertions that Dr. Chase discouraged them from getting a second opinion.

For all of these reasons, and those discussed below, the Board should decline to adopt the Committee's conclusion that Dr. Chase engaged in unprofessional conduct through his descriptions of cataracts, his communications with his patients, or his second opinion presentation. To the extent the Board is inclined to adopt the Committee's recommendation on any of these points, Dr. Chase respectfully requests the opportunity to provide the full Board with additional evidence, including the previously excluded testimony, of his professionalism.

In the final analysis, all of the available evidence points to the same conclusion: Dr. Chase did not act unprofessionally in any way. Instead, he provided his patients with the highest quality and most modern cataract care available in Vermont. The State was wrong to allege otherwise, and doubly wrong to summarily suspend Dr. Chase's license based on charges of purposeful unprofessional conduct that have now been proven false. The Board cannot restore Dr. Chase's ruined career. It can, however, provide him a small portion of the vindication he deserves by properly applying the law to all of the evidence, rejecting each of the State's

allegations of unprofessional conduct, and adopting all of Dr. Chase's proposed findings and conclusions.

II. The Committee's Report Exonerates Dr. Chase Of All Charges Of Purposeful Misconduct, Including All Of The Mistaken Allegations That Caused His Summary Suspension.

In July 2003, the State charged Dr. Chase with recommending and performing cataract surgery that he knew his patients did not need and falsifying his medical charts to justify his fraudulent recommendations. On the basis of these charges, the Board summarily suspended Dr. Chase's license and ended his career. Despite mounting evidence that its allegations were wrong, the State repeated its allegations of purposeful, dishonest conduct in its Amended Superceding Specification of Charges. Through that document, the State charged that Dr. Chase's practices constituted "willful," "immoral," and "dishonest" conduct, in violation of 26 V.S.A. §§ 1354(a)(14) and 1398, as well as "unfitness to practice medicine" in violation of 26 V.S.A. §§ 1354(a)(7). The State has never charged Dr. Chase with negligently or mistakenly mis-recording his patients' symptoms, diagnoses, or surgical decisions. It has never alleged that he failed to "thoroughly or adequately" discuss his patients' vision, visual needs, or treatment options with them or that his patient counseling was not sufficiently "collaborative." To the contrary, all of the conduct alleged by the State was purposefully dishonest. At the merits hearing, both parties focused their proof on those allegations of purposeful misconduct.

The Committee's Report completely exonerates Dr. Chase of all charges alleging that he recommended or performed surgery he knew his patients did not need or purposefully falsified his charts. It recommends ruling in favor of Dr. Chase on 93 of the State's 110 counts of unprofessional conduct, including all of the counts alleging that Dr. Chase engaged in "willful," "immoral," and "dishonest" conduct, in violation of 26 V.S.A. §§ 1354(a)(14) and 1398. It

firmly rejects all of the State’s charges that Dr. Chase’s conduct evidenced “unfitness to practice medicine” in violation of 26 V.S.A. §§ 1354(a)(8). In short, the Report concludes that the State was wrong with respect to its core allegations—the only allegations that might have justified the summary suspension of Dr. Chase’s license.

III. The Committee Found Only Violations Of Subsections 1354(a)(22) and (b).

While the Committee exonerated Dr. Chase of all purposeful misconduct, it has recommended that the Board find him in violation of 26 V.S.A. §§ 1354(a)(22) and 1354(b). Subsection 1354(a)(22) imposes a high standard that the State’s evidence failed to meet. Subsection 1353(b) is so vague as to render any finding of violation unconstitutional.

A. Subsection 1354(a)(22) Proscribes Only Heedless Violations Of Applicable Standards Of Medical Practice.

Subsection 1354(a)(22) makes it unprofessional for a physician, in the course of practicing medicine, to engage in a gross failure to use and exercise “that degree of care, skill and proficiency which is commonly exercised by the ordinary, skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.” With the exception of predicating unprofessional conduct on a finding of gross negligence, subsection 1354(a)(22) incorporates the same standard made applicable to civil medical malpractice lawsuits by 12 V.S.A. § 1908(1)-(2). That standard is an objective one that measures a doctor’s conduct against what a reasonable doctor would have done in the same or similar circumstances. *Rooney v. Medial Center Hospital of Vermont, Inc.*, 162 Vt. 513 (1994).¹

¹ In 12 V.S.A. § 1908(1), the legislature rejected a local, community standard of care in favor of a national standard of care, *Smith v. Parrot*, 175 Vt. 375, 380 (2003), and Vermonters are entitled to have the standard set forth in Section 1354(a)(22) also be based on national practices and standards.

In *Braun v. Board of Dental Examiners*, 167 Vt. 110 (1997), the Vermont Supreme Court reviewed the exact language contained in subsection 1354(a)(22),² and defined what is meant by a gross failure to practice in conformance with the required standard of care, stating:

We have repeatedly emphasized that grossly negligent conduct is more than a mere error of judgment, momentary inattention, or loss of presence of mind. Rather, it is the failure to exercise even a slight degree of care and an indifference to the duty owed.

Id. at 113-14 (citing *Hardingham v. United Counseling Serv. Of Bennington County, Inc.*, 164 Vt. 478, 481 (1995)); *Rivard v. Roy*, 124 Vt. 32, 35 (1963). It is “appreciably higher in magnitude and more culpable than ordinary negligence” and involves a “heedless and palpable violation of legal duty respecting the rights of others.” *Hardingham*, 164 Vt. at 481. As discussed below, none of Dr. Chase’s conduct violated this high standard.

B. Subsection 1354(b) Is Unconstitutionally Vague And Therefore Void.

Subsection 1354(b), which became effective in mid-2002, makes it unprofessional for a physician to fail to practice competently on one or multiple occasions. It further states:

Failure to practice competently includes, as determined by the Board: (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice.

26 V.S.A. § 1354(b). There was no allegation or evidence that Dr. Chase engaged in unsafe patient care. Moreover, as discussed below, subsection 1354(b)’s proscriptions of “unacceptable patient care” and “failure to conform” to the “essential standards of acceptable and prevailing practice,” are so vague as to be unconstitutional. Subsection 1354(b) cannot, therefore, be used to support a finding that Dr. Chase engaged in unprofessional conduct.

The Vermont Supreme Court has held:

² The underlying case involved a decision by the Board of Dental Examiners as to whether a defendant had engaged in the unprofessional practice of dentistry under, *inter alia*, the standard set forth in 26 V.S.A. § 809(a)(21). That standard is exactly the same as the one contained 26 V.S.A. § 1354(a)(22).

It is a basic principle of due process that a statute is void for vagueness if its prohibitions are not clearly defined. *Grayned v. City of Rockford*, 408 U.S. 104 (1972). A statute must be sufficiently clear to give a person of ordinary intelligence a reasonable opportunity to know what is proscribed. *Id.*; *State v. DeLaBruere*, 154 Vt. 237 (1990); *State v. Cantrell*, 151 Vt. 130, 133 (1989).

Brody v. Barasch, 155 Vt. 103, 110-11 (1990); accord *Braun v. Board of Dental Examiners*, 167 Vt. 110, 118 (1997) (citing and quoting *Brody* approvingly). Of course, “it is not necessary, or possible, for a statute that regulates a professional field to detail each and every act that is prohibited.” *Braun*, 167 Vt. at 118. Nevertheless, in order to pass constitutional muster under the Due Process Clause, the statutory language describing the standards must be sufficiently specific to convey “a definite warning as to proscribed conduct when measured by common understanding and practices.” *Braun*, 167 Vt. at 119 (quoting *Brody*, 155 Vt. at 111). The United States Supreme Court has explained the two reasons underlying the “void for vagueness doctrine”: (1) individuals should receive fair warning of what conduct is prohibited by the state; and (2) statutes must have standards explicit enough to prevent the state from applying them “on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application.” *Grayned*, 408 U.S. at 108-09; accord *Thibodeau v. Portuondo*, 486 F.3d 61, 65-66 (2d Cir. 2007).

Subsection 1354(b) provides that the failure to practice competently may constitute unprofessional conduct and that such conduct includes: (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice. It is not clear from this language what is meant by “essential standards” or “prevailing practice”; nor does the statute establish criteria for determining what is “acceptable practice” or “unacceptable care.” The Board has issued no regulations or decisions illuminating either standard.

When interpreted literally,³ the language of subsection 1354(b) makes any non-conformance, no matter how slight, with the “essential standards of acceptable and prevailing practice” unprofessional conduct. Under this reading, every Vermont physician who departs from the essential standards of the profession, through simple malpractice or otherwise, would be guilty of engaging in unprofessional conduct. This reading would transform every physician mistake into a potential disciplinary case. That cannot be what the Vermont legislature intended when it added subsection (b) to 1354 in 2002. If the literal language of the statute is ignored, however, there is no way to determine what magnitude of non-conformance or level of culpability is required to support a finding of unprofessional conduct. Is it negligent, grossly negligent, willful or intentional non-conformance that is required? Under any of those standards, must the deviation be significant, substantial, dangerous or something else in order to justify a finding of unprofessional conduct? It is impossible to tell from the vague language of the statute.

Divining the meaning of subsection (b) is complicated further when it is read in light of the relatively clear and definite language of subsection 1354(a)(22). That statutory provision defines as unprofessional only a physician’s gross failure in the practice of medicine to exercise the degree of care, skill and proficiency commonly exercised by the ordinarily skillful, careful and proficient physician in the same practice area. As discussed above, the objective reasonable physician and gross negligence standards set forth in subsection 1354(a)(22) are sufficiently definite and familiar to provide fair notice of the conduct proscribed and to prevent arbitrary or discriminatory enforcement by this Board or the Attorney General’s Office.

Logic and familiar rules of statutory construction mandate interpreting subsections 1354(a)(22) and (b) such that they each proscribe behavior substantially different from one

³ The Vermont Supreme Court has stated that the first step in interpreting a statute is to examine the entire statute with the purpose of giving effect to every word it contains. *Rochon v. State*, 177 Vt. 144, 147 (2004). If the statutory language is plain and unambiguous, the statute should be enforced as written. *Id.*

another. Although there may be some overlap in their prohibitions, they cannot be given interpretations that make one provision substantially superfluous. *Wood v. Eddy*, 175 Vt. 608, 609-10 (2003) (the court “will not construe a statute to render a significant part of it pure surplusage”); *see also Rochon v. State*, 177 Vt. 144, 149-50 (2004)(where statute imposed liability on emergency responders for driving in reckless disregard of others’ safety, the court refused to interpret it to also permit a simple negligence lawsuit because to do so would render the gross negligence clause—“reckless disregard”—ineffectual surplusage).

If subsection 1354(b)’s “essential standards of acceptable and prevailing practice” were interpreted to apply to substantially the same practices of medicine governed by subsection 1354(a)(22)’s “reasonable physician standard,” it would necessarily render one of those subsections superfluous. One of the two statutory provisions would be turned into “ineffectual surplusage,” depending on the level of culpability inserted into subsection 1354(b). For example, if a strict liability or simple negligence standard were adopted for subsection (b), every violation of subsection (a)(22)’s gross negligence standard would necessarily violate subsection (b) and thereby render subsection (a)(22) entirely superfluous. Conversely, if a gross negligence, willfulness or intentional standard is read into subsection 1354(b), then that subsection would itself be entirely superfluous as every violation of it would also be a violation of subsection (a)(22)’s gross negligence standard.

The Board could avoid rendering either subsection (a)(22) or (b) superfluous by interpreting subsection (b) in one of two ways: (1) the Board could rule it applies to behavior substantially different in nature than that regulated under subsection (a)(22); or (2) the Board could conclude that it applies only to some limited portion of the practice of medicine regulated by subsection (a)(22) and it also applies a lesser standard of culpability than subsection (a)(22)’s

gross negligence standard. This Board, however, lacks the authority to give either interpretation to subsection (b) because it has absolutely no guidance on what conduct the legislature intended it to address or under what standards the legislature intended such conduct to be judged.

Moreover, even if this Board had authority to adopt reasonable rules defining conduct prohibited by subsection (b), it could not exercise that authority in the middle of a contested case by defining the scope of subsection (b)'s prohibition and applying it to prior conduct. Such an approach would rob the respondent physician of the fair notice and warning he or she is constitutionally entitled to receive. At bottom, the fundamental problem with subsection 1354(b) is that it is impossible to determine what behavior it applies to and what standard should be employed to judge whether such behavior is unprofessional. For this reason alone, the Board must reject any finding that Dr. Chase's conduct violates subsection 1354(b). Moreover, as discussed below, even if subsection 1354(b) were valid, none of Dr. Chase's conduct violated its terms, however they are construed.

IV. Dr. Chase Did Not Act Unprofessionally When Describing His Patients' Visually Significant Cataracts As Dense.

The Committee Report points to Dr. Chase's description of his patients' cataracts as "dense" as one of three purported violations of subsections 1354(a)(22) and (b). These findings are legally and factually wrong, and the Board should decline to follow them.

A. The Evidence Demonstrates That Dr. Chase's Cataract Descriptions Were Appropriate.

In order to aid their diagnoses and treatment recommendations, most ophthalmologists describe, or grade, their patients' cataracts in their medical charts. However, as the Committee recognized, there exists no requirement that ophthalmologists describe or rate the physical severity of their patients' cataracts. (Committee Report Findings of Fact ("FF") ¶ 101.)

Moreover, those ophthalmologists who do rate their patients' cataracts do not all use the same system. (FF ¶ 101.) Every doctor who testified applied his or her own rating system differently. The State's own ophthalmologists also freely admitted that all rating scales used to describe cataracts are highly "subjective," "nebulous," and "imprecise." (Respondent's Proposed Findings ("PF") ¶ 164.) As a result of this imprecision, the Committee properly found that doctors do not rely on one another's descriptions of cataracts to guide their surgical decisions; they always examine and grade their patients' cataracts themselves, using their own systems. (FF ¶ 107.) Indeed, the State was unable to introduce a shred of evidence that anyone—whether a doctor, a patient, or a payor—was ever misled by Dr. Chase's (or anyone else's) cataract descriptions. For these reasons, a physician is free to use the descriptive system that best helps him or her provide quality care to patients. (PF ¶ 159.)

The Committee correctly concluded that, in the end, a physician's rating system exists solely to help him or her determine "whether and to what extent the cataract interferes with the patient's functional vision." (FF ¶ 101.) The Committee then accurately described Dr. Chase's method for describing his patients' cataracts in his charts, and it conforms precisely to the rationale the Committee endorsed:

In diagnosing and describing his patients' cataracts, Dr. Chase found it more helpful to him, 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.

(FF ¶ 108.) Nonetheless, the Committee proceeded to recommend that Dr. Chase be adjudged unprofessional for his use of the word "dense" to describe cataracts that other doctors described as "early" cataracts, "trace" cataracts, or cataracts rated "1" or "2" on a scale of 1 to 4.

In support of this recommendation, the Committee states:

[A] cataract described as dense is a cataract that presents characteristics that may be associated with a higher risk for interoperative and postoperative complications. Those characteristics include appearing opalescent, brunescient, or black. Cataracts described as dense are mature and opaque and tend to allow little or no light to pass through them. Cataracts described as dense are more clinically significant than cataracts described as early or trace.

(FF ¶ 106.) Although the Committee first defines a “dense” cataract to mean one that is “black,” it later indicates that a “dense” cataract may be “whitish.” (FF ¶ 252.) The Report makes no attempt to reconcile this apparent contradiction. Nor does it reference any record support for its conclusions. In its Conclusions of Law, the Committee simply states that Dr. Chase’s use of the term “dense” is “not in line with the general understanding of the descriptive use of that term or with the AAO PPP characterization of dense cataracts.” (*See, e.g.*, Committee Report Conclusions of Law (“CL”) ¶ 61.) It defines neither this “general understanding” of dense nor the AAO PPP’s characterization. Whatever the definition, the Committee’s conclusion that there exists a standard definition of “dense,” or even certain attributes that “dense” must denote, has no support in the record evidence, and is contrary to the only expert testimony on the subject.

As an initial matter, the AAO PPP contains absolutely no definition of what a “dense” cataract must be. (*See* Hearing Ex. 503B.) In fact, it contains no cataract description system at all. On page 27 of the AAO PPP, the authors describe some “high risk” characteristics of certain cataracts. (*Id.* at 27.) In that context, the authors of the AAO PPP include a description of what they mean by “dense” cataracts for the purpose of that specific and limited discussion: a brunescient or black nuclear cataract. The AAO found it necessary to ascribe a meaning to the term “dense” for its limited purposes because the term has no standardized meaning within ophthalmology. Even then, the authors’ description contains few of the characteristics that the Committee assigns to the word, omitting any reference to “opalescent,” “mature,” “opaque,” or “whitish.” The Committee’s apparent reliance on this single reference as a “definition” or

“standard” that must be observed by all physicians, lest they risk disciplinary charges, is improper.

Nor did any of the State’s expert witnesses testify that “dense” has a standardized meaning. To the contrary, in direct contradiction of the Committee’s recommendation, Dr. Guilfooy testified that it is appropriate for an ophthalmologist to use “dense” to describe visually significant cataracts if it helps the doctor delivery quality care. (PF ¶ 159.) Similarly, Dr. Cavin, like Dr. Chase, uses the descriptor “dense” in part to “describe to [him]self what [he] expect[s] its impact on vision to be.” (PF ¶ 181.) Dr. Alan Irwin, in turn, refuses to use the descriptor “dense” precisely because, to him, it is too imprecise to be useful. (PF ¶ 27.) No physician testified that he or she uses the term “dense” solely to denote cataracts that are black, white, opalescent, brunescant, or any other color.

In short, the record is devoid of any evidence that there exists a standard definition of “dense,” much less the definition the Report adopts. It is the *State’s* burden to prove by a preponderance of the *evidence* that dense has a well-defined meaning that all ophthalmologists must adhere to. Neither the State, the Committee, nor the Board has the freedom to impose its own definition of “dense.” The Committee’s definition is both without record support and contrary to law. As a result, the Board must decline to endorse it. It is wrong to label one physician’s grading system as a failure to meet the standard of care, much less a “gross failure” or “incompetence,” simply because it is different—even vastly different—from another’s.⁴

⁴ Moreover, the Committee erred in determining that a simple charting practice constitutes a gross failure of “care, skill, or proficiency” as required by 26 V.S.A. § 1354 (a)(22). There was no evidence that Dr. Chase’s decision to label his patients’ early cataracts as “dense” had anything to do with his care, skill or proficiency. It was simply a charting convention that misled no one.

B. Dr. Brown Prejudged The Issue, Depriving Dr. Chase Of A Fair Hearing.

The Committee's desire to find a standard definition of a "dense" cataract where none exists appears to have sprung from the preconceived, firmly held, but unsupported, conviction of the Ad Hoc panel member, Dr. Dewees Brown, that it is necessarily improper to label as dense anything but the most mature, heavy, or opaque cataract. On the second day of the merits hearing, before the Committee had heard any evidence of what "dense" does or does not mean in ophthalmology, Dr. Brown demonstrated that he had already reached his own unshakable conclusion that it is simply wrong for an ophthalmologist to utilize "dense" in a functional way in order to denote a cataract that is visually significant. Dr. Brown revealed his prejudice on this issue again and again in his comments to Dr. Chase:

I feel that most people would interpret dense as a heavy, dense cataract that would obviously show up through a slit lamp.

(9/12/06 Hearing Tr. at 78.)

A dense cataract is a heavy cataract which you really have a lot of difficulty seeing through Now maybe you interpret [dense in a different, functional] way, but other people are not going to interpret it that way.

(*Id.* at 83.)

[I]f you're talking about functionally dense, you should state functionally dense, not dense.

(*Id.* at 87.)

When you are describing a physical finding and then put a functional finding along with it, it makes no sense. If dense is functional, dense is functional. If it's a central nuclear cortical cataract, there is a central nuclear cortical cataract. You can't describe it as dense because you're describing a physical thing and putting a functional adjective on it. Doesn't work.

(*Id.* at 101-02.)

Dr. Brown also objected vigorously to the introduction of evidence that was contrary to his preconceived notion that only dark, heavy cataracts can cause visual problems. In countering the State's charges and Dr. Brown's expressed opinions, Dr. Chase presented a 2006 peer-reviewed article appearing in the AAO's premier publication, Ophthalmology, and based on the groundbreaking 20 year long Beaver Dam Study of cataract patients. The Beaver Dam Study confirmed that early and mild appearing cataracts—even those rated as 1 or less on a four point scale—often cause significant functional vision loss in patients. (PF 101, 161.) Although those symptoms are not always accompanied by a decrease in Snellen visual acuity (but are often reflected in reduced CST scores), they can be remedied through cataract surgery. (PF ¶ 104.) The Beaver Dam Study concludes with a statement that confirms the principle that Dr. Chase applied in his cataract practice: “[L]ens opacities even in relatively early stages are accompanied by diminished visual function.” (Hearing Ex. 819.)

The Beaver Dam Study was admitted into evidence over the strong and emotional objection of Dr. Brown. (*See, e.g.*, 10/26/06 Hearing Tr. at 204-07, 221-222.) Its conclusions went unchallenged at the merits hearing. Those conclusions were central to Dr. Chase's defense. Nonetheless, the Committee omitted all reference to the Study from its Report.

The Committee's and Board's decisions must be based on the record evidence, not the preconceived opinions of Board members, even if they are physicians.⁵ As the Supreme Court has put it, “Not only is an unbiased decisionmaker constitutionally unacceptable, ‘but our system of law has always endeavored to prevent even the probability of unfairness.’” *Withrow v. Larkin*, 421 U.S. 35, 47 (1975) (quoting *In re Murchison*, 349 U.S. 133, 136 (1955)). “An administrative hearing of such importance and vast potential consequences must be attended, not

⁵ Dr. Chases expert, Dr. Freeman, testified that the charting practices of ophthalmologists and general practitioners differ greatly from one another, and that ophthalmologists' records are subject to much wider variation and subjectivity. (PF ¶ 180.)

only with every element of fairness, but with the very appearance of complete fairness. Only thus can the tribunal conducting a quasi-adjudicatory proceeding meet the basic requirement of due process.” *Texaco, Inc. v. FTC*, 336 F.2d 754, 760 (D.C. Cir. 1964)(internal quotations omitted). Where the factfinder demonstrates that he has preformed opinions regarding the facts of a proceeding, the litigants are denied their constitutional right to an unbiased decisionmaker. *See American Cyanamid Co. v. FTC*, 363 F.2d 757, 765 (D.C. Cir. 1966). It is clear from Dr. Brown’s comments, questions, and demeanor during the hearing that he preformed opinions regarding Dr. Chase’s use of the descriptor “dense.” Those preformed opinions are identical to the Committee’s ultimate findings on the issue. Because Dr. Brown’s prejudice denied Dr. Chase his due process right to a fair hearing, the Board must reject the Committee’s recommendation.

V. Dr. Chase And His Staff Properly Communicated With His Patients Regarding Their Vision, Visual Needs, And Lifestyle Impairments.

The Committee next recommends that the Board find Dr. Chase in violation of subsections 1354(a)(22) and 1354(b) because he did not engage in a “thorough collaborative process,”⁶ and did not “thoroughly and adequately discuss” with his patients whether their quality of vision was meeting their needs or whether their quality of life was compromised by their vision. (*See, e.g.*, FF ¶¶ 37, 73.) The Committee’s findings in this regard are legally and factually deficient for a number of reasons.

⁶ The Committee found, without citation to the record, that there should be “a thorough collaborative process between the physician and the patient to determine whether the patient is able to function adequately with his or her present level of vision; whether the patient’s vision, with or without corrective lenses, is meeting the patient’s needs; and the extent to which vision may be compromising the patient’s quality of life.” (FF ¶ 37; *see also* FF ¶ 73.)

A. Dr. Chase And His Staff Thoroughly Addressed His Patients' Vision And Lifestyle Impairments, As Well As Their Treatment Options.

The evidence regarding Dr. Chase's patient education permits only one conclusion: Dr. Chase and his large and well-trained office staff utilized multiple tools to assess and communicate with his patients regarding their vision and lifestyle impairments. In fact, Dr. Chase's practice provided his patients with more information regarding these important facts than any other Vermont ophthalmologist who testified. While most of the State's testifying physicians performed only Snellen testing and spoke with their patients for five to fifteen minutes regarding their cataracts, symptoms, and surgical options, Dr. Chase's office employed a much more comprehensive approach to diagnosis, patient education, and informed consent.

At the outset of every full patient examination, Dr. Chase's office asked each patient to fill out an Eye Health History form, on which the patient was asked to self-report her medical history and visual symptoms. (FF ¶ 80; PF ¶ 114.) Beginning in approximately 2002, each patient that had been previously diagnosed with cataracts was also asked to fill out a Lifestyle Questionnaire, on which she was asked to self-report any of the ways in which vision was compromising her lifestyle. (FF ¶ 81; PF ¶ 115.) The Lifestyle Questionnaire used by Dr. Chase was based on a published, peer-reviewed questionnaire, and was an effective tool to identify and document cataract-induced visual defects. (*Id.*) That same peer-reviewed research demonstrated that lifestyle questionnaires are one of the most effective and accurate ways to assess patients' real life visual needs and abilities. (PF ¶¶ 43, 44.) Although both the 1996 and 2001 versions of the AAO PPP recommend that ophthalmologists use such cataract-specific lifestyle evaluation tools, Dr. Chase was the only testifying physician who did so. This fact alone forcefully demonstrates that Dr. Chase was assessing and communicating his patients' lifestyle impairments more thoroughly, and in more ways, than the standard of care requires.

After filling out these forms, each patient was further interviewed about her symptoms by one of Dr. Chase's technicians, who noted any additional reported symptoms in the patient's chart, placing quotation marks around exact quotes from the patient. (FF ¶ 83; PF ¶ 118.) The technician then took each patient through a battery of visual tests that was more comprehensive than that performed by any other physician, including multiple assessments of the patient's Snellen vision, contrast sensitivity and glare vision, and visual fields, among others. (FF ¶¶ 84-87; PF ¶¶ 119-125.) At the conclusion of these tests, the patient was examined by Dr. Chase, who began each examination by further questioning his patients as appropriate, using their Eye Health History Forms, their Lifestyle Questionnaires, and the technicians' histories to guide his questioning. (PF ¶ 126.)

If, after performing a full examination, Dr. Chase believed that a patient was a proper candidate for cataract surgery, he summarized the risks and benefits of the procedure and referred that patient to his nurse for an extensive counseling and informed consent discussion. (FF ¶ 116; PF ¶¶ 193, 201.) That informed consent process was specifically designed to allow the patients to assess their own visual needs and limitations so that they could make an informed decision regarding the wisdom of proceeding with cataract surgery. (PF ¶¶ 208-222.)

Although there was no requirement that the counseling be performed by a trained nurse, Dr. Chase always hired RNs for the position. (PF ¶ 201.) Dr. Chase considered the nurse's informed consent presentation as an integral part of his examination. (PF ¶ 221.) The counseling nurse spent between one and 1.5 hours with each patient, discussing the patient's vision and visual needs, describing cataracts and cataract surgery, reviewing the risks and benefits of surgery, and taking pre-operative measurements of the patients' eyes. (PF ¶ 204.) Other doctors' informed consent processes took between 5 and 15 minutes. (PF ¶ 205.)

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

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

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

(PF ¶ 209 (emphasis added).)⁷ Dr. Chase’s informed consent document is far more comprehensive than the generic forms used by all ophthalmologists who perform surgery at Fletcher Allen. (PF ¶ 210.) It is the only consent form introduced at trial that emphasizes that patients should only have surgery if they feel they “cannot function adequately due to poor sight produced by a cataract”—the very information that the Committee found was lacking from Dr. Chase’s patient communications.

Unlike nearly every other doctor who testified, Dr. Chase did not require his patients to sign the informed consent form on the day they scheduled the surgery. Instead, he asked every patient to take the document home, review it, discuss it with family, and call with any follow-up questions. The patients were only required to sign the informed consent document on the day of surgery, after all of their questions were addressed. (PF ¶ 211.)

Surgical patients were also provided with educational cataract pamphlets pre-printed by the AAO, the largest and most mainstream organization of ophthalmologists. That pamphlet informed patients: “With few exceptions, the presence of a cataract will not harm your eye

⁷ In an important oversight, Dr. Chase’s extensive informed consent form is not even mentioned in the Committee’s Report.

Many people have cataracts but can still see well enough to do the things they enjoy. The decision is up to you.” (PF ¶ 212 (emphasis added).) In short, the entirety of the informed consent process was designed to reinforce to Dr. Chase’s patients that the decision to have surgery depended on whether their vision was meeting their lifestyle needs—the very thing the Committee found lacking in Dr. Chase’s communication with his patients.

B. The State Never Charged Dr. Chase With Committing Unprofessional Conduct By Failing To Sufficiently Collaborate Or Communicate With His Patients.

The Committee’s findings regarding Dr. Chase’s failures in patient communication are legally as well as factually deficient. As an initial matter, the State never charged Dr. Chase with failing to “collaborate” or “thoroughly and adequately” communicate with his patients regarding their visual needs and quality of life. As discussed above, the charges against Dr. Chase are based almost solely on allegations of purposeful and dishonest conduct.

The State first introduced allegations of inadequate communication and collaborative processes in its Post-Trial Brief, which it filed only after it knew it had failed to prove the purposeful misconduct that it had actually charged. Due process demands that, at a minimum, Dr. Chase be given notice of the charges against him and an opportunity to present evidence to meet those charges at trial. *See, e.g., Brock v. Roadway Express, Inc.* 481 U.S. 252, 264 (1987). Consistent with these due process and notions of fundamental fairness, the State cannot raise new allegations of unprofessional conduct after the trial has concluded, and the Board cannot find Dr. Chase guilty of unprofessional conduct with which he was not charged. For this reason alone, the Board must reject the Committee’s invitation to punish Dr. Chase for alleged inadequacies in his patient communication skills and methods, even if it finds them to be deficient.

C. The State Introduced No Evidence Of The Vague Standard Of Care It Now Seeks To Impose, Which Is At Odds With Vermont Law.

Just as it did not charge Dr. Chase with failing to “collaborate” and “thoroughly and adequately communicate” with his patients regarding their vision and visual needs, the State introduced absolutely no evidence of such a standard of care. Instead, in its post-trial submissions the State manufactured both its allegation and its purported standard from whole cloth, without ever attempting to define what it means.

Unsurprisingly, no such vaguely defined standard of care exists. Rather, Vermont law imposes on every physician a very specific duty to “disclose to the patient such alternatives [to the proposed treatment] and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.” 12 V.S.A. § 1909. The evidence adduced at the merits hearing demonstrates that Dr. Chase’s office exceeded this standard. The Board can impose no other.

In articulating its invented standard, the State implies, and the Committee seemed to accept, that the ophthalmologist, not the patient, must decide that the patient’s lifestyle is impaired. That position is directly contrary to all of the State’s own evidence, which demonstrated that only the patient can make that decision. (PF ¶¶ 95, 96.) Dr. Chase and his staff provided all of his patients the opportunity, information, and tools to make that decision wisely. The Committee may have preferred that Dr. Chase handle his patient communications differently, but there can be no doubt that those communications satisfied the standard of care.

D. The Board Excluded Important Evidence Of Patient Counseling.

Unfortunately, the Committee was not allowed to hear all of the relevant evidence regarding the extensive counseling performed by Dr. Chase's staff, because the State successfully excluded it at the merits hearing, arguing it was irrelevant. However, if it intends to accept the Committee's conclusion that Dr. Chase be adjudged unprofessional based on his purported lack of communication with his patients, the Board must hear the excluded evidence prior to ruling. That evidence includes, but is not limited to, the excluded testimony of Dr. Chase's counseling nurses, including Ellen Flanagan, R.N., and Dr. Chase's wife, Brianne Chase.

Brianne Chase is Respondent's wife and provided high-level oversight of the non-clinical aspects of Dr. Chase's medical practice. She also hired all of the practice's employees. If allowed to testify on this topic, Ms. Chase would have told the Committee that Dr. Chase had a very businesslike demeanor when treating patients, focusing intently on their medical care, but little on his own chairside manner. (Transcript of Brianne Chase Federal Trial Testimony, submitted in support of Dr. Chase's Evidentiary Proffer, at 60-63.) His singular focus on the patients' health was sometimes misinterpreted by patients and staff alike as being gruff, abrupt, or dismissive of other considerations. (*Id.*) Dr. Chase took steps to make certain that his patients nonetheless received empathic, as well as high quality care. For instance, he hired a nurse "whose only job was to educate the patients and communicate with them about the surgery, and deal with all their feelings and everything he wasn't good at." (*Id.* at 67.)

Ellen Flanagan, R.N., was employed by Dr. Chase as a surgical counselor. Ms. Flanagan has been a Registered Nurse for over 30 years. (Transcript of Ellen Flanagan Federal Trial Testimony, submitted in support of Dr. Chase's Evidentiary Proffer, at 3.) Ms. Flanagan's

responsibilities included the pre-operative teaching and counseling of candidates for cataract surgery. (*Id.* at 10.) Dr. Chase preferred to have someone with “the resources,” “the expertise,” and the “knowledge base” of an R.N. in that role. (*Id.* at 12.)

Although Dr. Chase was ultimately responsible for making certain that the informed consent process was complete, Ms. Flanagan 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.” (*Id.* at 23.) As a result, she spent between 1 and 1.5 hours with each patient, helping them understand their treatment choices and the consequences of those choices. (*Id.* at 32.)

Ms. Flanagan told each patient that cataract surgery was elective. (*Id.* 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.) Ms. Flanagan 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.)

As part of her teaching, Ms. Flanagan 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:

I’d say, This is information that you need to know to safely have this operation. . . . *[Y]ou need to know this information to make up your mind whether surgery is all right for you or not. It’s important to educate yourself about this to your satisfaction, and I said, I’ll respect whatever decision you make as long as I know that I have informed you the best that I can. . . .* I said, you need to read

this consent form and be comfortable with it, and whatever questions you may have about it answered to your satisfaction.

(*Id.* at 41.) The patients were then sent home with the form, asked to discuss it with their families, and encouraged to call Dr. Chase's office if they had any questions. (*Id.* at 42-43.)

Ms. Flanagan 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." She attempted to make up for this "shortfall" in Dr. Chase's chairside manner:

[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.

(*Id.* at 59-60.) Dr. Chase was unique among all of the testifying doctors in presenting his patients with such a comprehensive counseling opportunity. The Committee's recommendation that he failed to adequately and thoroughly discuss his patients' visual needs and lifestyle impairments is at odds with this evidence and should be rejected.

E. Dr. Chase Properly Shared Some Of The Patient Counseling And Communication With His Staff.

Although the Committee's Report does not explicitly say so, it could be interpreted to criticize Dr. Chase for supplementing his own informed consent presentation with patient counseling performed by his staff, rather than performing it all himself. However, the State introduced absolutely no evidence that this supplementation was improper, much less

unprofessional. To the contrary, two separate experts confirmed that having the detailed informed consent presentation administered by someone other than Dr. Chase was another benefit to his patients. Dr. Jonathan Javitt, who conducted the single largest survey of cataract practices in the United States, testified that utilizing a registered nurse to deliver the detailed informed consent is an extraordinarily good practice because it allows the patient to weigh the risks and benefits of surgery outside of the physician's presence and implicit influence. (PF ¶ 222.) Dr. Freeman agreed that it is advantageous for a physician to delegate the informed consent process to a nurse, because some patients communicate more comfortably with a nurse than with a physician. (PF ¶ 221.) This was particularly true in Dr. Chase's office because he and his staff knew that not all patients responded well to Dr. Chase's straightforward communication style, and his nurses worked successfully to make certain that his deficits as a communicator did not compromise patient care.

F. Dr. Chase's Surgical Patients All Had A Complete Understanding Of Their Vision And Visual Impairments Prior To Choosing Surgery.

The best evidence of the effectiveness of Dr. Chase's counseling process is the complaining patients themselves. Of the 11 complaining patients, only three—Ms. Salatino, Ms. McGowan, and Ms. Lang—actually chose to have surgery after completing the counseling process. That fact alone strongly supports the notion that Dr. Chase and his office gave his patients all the information and guidance they needed to make their own informed choices regarding surgery. Moreover, all three surgical patients testified that the informed consent process provided them with the information they needed to make an intelligent decision regarding surgery and emphasized that they should only proceed with surgery if their vision was not meeting the needs imposed by their lifestyles.

Ms. Salatino understood from the informed consent form and the pamphlets that the decision whether to have the surgery was hers to make, that she should not have the surgery unless the cataract was preventing her from doing something she wanted or needed to do, and that waiting to have the surgery until she was comfortable with it would not compromise the outcome. (PF ¶¶ 337-38.) She used the five weeks between her informed consent teaching and the surgery to consider whether her vision was still meeting her needs. (PF ¶ 340.) After this period of reflection, she decided to proceed with the surgery.

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

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

The remaining patients decided not to go forward with cataract surgery, and therefore did not complete the full patient education and informed consent process. Many, such as Mr. Touchette and Mr. Augood, exited Dr. Chase's office without even bothering to see the nurse as Dr. Chase had requested. The fact that these patients felt free to decline surgery demonstrates

that Dr. Chase did not pressure patients into surgery. However, the fact they felt that they did not receive an adequate or collaborative presentation regarding their vision, visual needs, and treatment options cannot be held against Dr. Chase.

In sum, the Committee is mistaken when it concludes that Dr. Chase did not thoroughly and adequately communicate with his patients regarding their vision, their visual needs, and their lifestyle impairments. Nothing could be further from the truth. Dr. Chase and his staff designed a counseling process that was intended to, and did, accomplish just that. The evidence, both admitted and excluded, supports no other conclusion.

VI. Dr. Chase Did Not Act Unprofessionally When Informing His Patients About Second Opinions.

In its third and final finding of unprofessional conduct with respect to most of the complaining patients, the Committee concluded that Dr. Chase's statements to patients regarding second opinions, and the manner in which those statements were recorded in the patients' charts, were "misleading, confusing, and improper." (*See, e.g.*, FF ¶ 115.) The Committee's findings ignore the reason for Dr. Chase's statements regarding second opinions and misapprehend the evidence regarding how those statements were recorded in his charts.

Dr. Chase offered uncontradicted testimony regarding how he addressed the issues of surgery with each of his cataract patients if he believed that a patient should consider the option of cataract surgery. 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. (PF ¶ 192.) If the patient responded "yes," Dr. Chase would summarize the potential risks and possible benefits of cataract surgery. (PF ¶ 193.) 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, it's not going to damage her eyes *not* to have the surgery.” (PF ¶ 194.) Importantly, Dr. Chase did not tell his patients that other physicians would confirm his recommendation of surgery. To the contrary, he informed them that another doctor might well disagree with his recommendation. (PF ¶ 198.) Dr. Chase never, ever told his patients that they should not seek a second opinion. (Hearing Tr. 9/11/06 at 199-201; 9/12/06 at 197-98; 9/21/06 at 121-22, 159, 208; 9/25/06 at 84, 87-88, 142, 159; 9/26/06 at 7.)

Dr. Chase's technicians recorded his “second opinion” conversation in his patients' charts with the shorthand notation, “second opinion given.” The undisputed evidence showed that Dr. Chase did not instruct them to record it in this manner. (PF ¶ 197.)

Dr. Chase testified that his 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. (PF ¶ 195.) As a result, his hypothetical second opinion that surgery was *not* necessary was just one part of his more extensive informed consent process. (PF ¶ 195.) Although it went unchallenged at trial, Dr. Chase's explanation for his hypothetical second opinion is entirely absent from the Committee's Report.

Notably, the Committee did not rule that Dr. Chase's standard presentation was improper. Nor could the Committee come to such a conclusion based on the evidence. Dr. Freeman and Dr. Javitt testified that Dr. Chase's use of a hypothetical second opinion to illustrate the elective nature of cataract surgery was not misleading or improper. (PF ¶ 196.) One of the State's experts, 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. (PF ¶ 199.) Dr. Javitt used a similar presentation with his glaucoma patients, telling them that if they seek a second opinion, other physicians in the area may not choose to treat their condition surgically. (PF ¶ 200.)

Instead of taking Dr. Chase's testimony at face value, the Committee found that his explanation of his standard presentation, and the reasons therefore, was "not credible." (FF ¶ 115.) The Committee instead chose to credit the testimony of a handful of Dr. Chase's patients who said that he affirmatively discouraged them from receiving a second opinion. This testimony was directly contrary to Dr. Chase's testimony of what he told every patient, including the complainants. The Committee went on to conclude that, as recounted by these few patients, Dr. Chase's presentation or charting as to 10 of the 11 complaining patients was misleading, confusing, and improper. On this basis, it found that Dr. Chase's statements and recordkeeping regarding his second opinion presentation constituted a gross deviation from the standard of care, in violation of 26 V.S.A. § 1354(a)(22), and a failure to practice competently, in violation of 26 V.S.A. § 1354(b). The Committee rejected the State's charges that this conduct was immoral, unprofessional, or dishonest, in violation 26 V.S.A. § 1398, or that it evidenced unfitness to practice medicine, in violation of 26 V.S.A. § 1354(a)(7).

The Board should decline to accept the Committee's recommendation that Dr. Chase violated section 1354(a)(22) or 1354(b) through his second opinion presentation for several separate, dispositive reasons. First, the State did not charge Dr. Chase with those violations. Second, the Board excluded important evidence regarding the fact that Dr. Chase's patients were encouraged to get second opinions if they desired. Third, as discussed extensively below, the testimony of many of the complaining witnesses was not sufficiently credible to justify findings

of unprofessional conduct, particularly in the face of Dr. Chase's consistent testimony of what he told every cataract patient.

A. The State Did Not Charge Dr. Chase With The Unprofessional Conduct Found By The Committee.

The Committee concluded that, as to each patient except Dr. Olson, Dr. Chase's statements and/or charting regarding his hypothetical "second opinion" violated 26 V.S.A. § 1354(a)(22) because it constituted a gross failure to use the common degree of care, skill, or proficiency. As to seven of the 11 patients, the Committee concluded that these same actions constituted a failure to practice competently in violation of 26 V.S.A. § 1354(b). The Board must reject both of these sets of recommendations for one fundamental legal reason: The State's Amended Superseding Specification of Charges does not charge that Dr. Chase's "second opinion" statements or charting violated either section 1354(a)(22) or 1354(b).

A careful review of the Specification reveals that none of the counts alleging violations of sections 1354(a)(22) or 1354(b) even mentions Dr. Chase's practices with respect to second opinions. Putting aside the counts alleging purposeful chart falsification that the Committee rejected, the State only charged Dr. Chase with unprofessional conduct related to second opinions with respect to four of the 11 complaining patients (Nordstrom, Lang, Augood, and Kerr). In those instances, the State alleged that Dr. Chase discouraged his patients from receiving second opinions in violation of 26 V.S.A. § § 1354(a)(7) (unfitness to practice medicine) and 1398 (immoral, unprofessional, and dishonest conduct). The Committee rejected these charges as well. The Committee's finding that Dr. Chase committed any type of unprofessional conduct by discouraging Ms. Salatino, Mr. Cole, Ms. McGowan, and Mr. Touchette from receiving a second opinion is even more lacking in legal support: The

Specification contains no counts alleging that Dr. Chase violated any rules of professional conduct by discouraging any of these patients from receiving second opinions.⁸

As discussed above, the Due Process Clause does not allow the Board to convict Dr. Chase of unprofessional conduct with which he was not charged, even if it disagrees with Dr. Chase's practices. For this reason alone, the Board must decline to follow the Committee's recommendations as to Dr. Chase's statements and charting regarding second opinions.

B. The State Succeeded In Excluding Relevant Evidence Regarding Second Opinions.

The State also successfully excluded certain evidence that Dr. Chase's patients were encouraged to receive second opinions regarding Dr. Chase's surgical recommendations. As a result, the Committee's conclusion that some patients were discouraged from receiving second opinions was not based on all of the available, relevant evidence. As noted above, the State successfully excluded testimony from Dr. Chase's counseling nurses, including Ellen Flanagan and Mary Clairmont. If allowed to testify, Ms. Flanagan would have told the Committee that when a patient asked about getting a second opinion, she told the patient:

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.

(Transcript of Federal Trial Testimony of Ellen Flanagan, submitted in support of Dr. Chase's Evidentiary Proffer, at 52.) Ms. Clairmont, too, would have testified that she encouraged patients to receive second opinions if they were uncomfortable with Dr. Chase's recommendations. This testimony, if introduced to the Committee, would have forcefully rebutted the State's claim that Dr. Chase was discouraging his patients from receiving second

⁸ Moreover, Dr. Chase's method of charting second opinions could not violate section 1354(a)(22) even if it were charged. Subsection (a)(22) only addresses failures regarding physicians' "care, skill and proficiency," not charting practices.

opinions. If, despite the arguments set forth above, the Board is inclined to credit the Committee's recommendation, it should allow Dr. Chase to present the relevant evidence that was improperly excluded at the hearing prior to rendering its decision.

VII. The Committee Did Not Perform A Meaningful Analysis Of Each Patient's Credibility.

The State's Superseding Specification of Charges implicates the eye care that Dr. Chase provided 11 of his thousands of patients over the course of three decades. As a result, Dr. Chase candidly testified that he was unable to recall most of his specific interactions with the complaining patients and, instead, testified based on his medical charts and the common practices he employed with all of his patients. For instance, as discussed above, he testified regarding what he told, and did not tell, each and every patient regarding second opinions. The State's experts—Drs. Irwin, Cavin, Guilfooy, Cleary, Morhun, and Watson – did the same. They had no recollection of treating the specific complaining patients, but instead testified about their care based on their own medical charts and their knowledge of their own standard practices. Because neither Dr. Chase nor the State's experts could recall most of their interactions with the complaining witnesses, it is particularly important for the Committee, and the full Board, to perform a searching evaluation of each complaining witnesses' credibility. Absent such an evaluation, the Board's decision could be based on testimony that is the product of a faulty memory, bias, or both.

Unfortunately, the Committee performed almost no evaluation of the memories or credibility of the complaining witnesses. Instead, as to almost every patient witness, the Report recites the identical conclusion: "The Committee finds that [he or she] is a credible witness, who is able to accurately recollect and testify about [his or her] interactions with Respondent." (*See, e.g.,* FF ¶ 228.) While the Committee was understandably reluctant to call into question the

memories and credibility of the patients who stepped forward to complain about a physician, the evidence demonstrates the necessity of doing just that. Nearly every witness gave testimony regarding Dr. Chase that was demonstrably incorrect, and those mistakes—whether innocent or purposeful—call into question some of the most important evidence against him.

In light of these witnesses' repeated failures of credibility, the Committee was wrong to credit their testimony regarding Dr. Chase's examinations and communications where it conflicted with his testimony regarding his standard practices and charting methods employed with all patients. For instance, the Committee erred in concluding, as it did, that Dr. Chase discouraged some patients from receiving a second opinion. It erred in concluding that some patients were not bothered by their visual symptoms, even though they self-reported those symptoms to Dr. Chase and his technicians as recorded by the patients and technicians in the medical charts. And it erred in concluding, based on patient testimony, that Dr. Chase and his staff did not thoroughly and adequately discuss his patients' vision, visual needs, and treatment options with them. The Board should credit Dr. Chase and his reliable testimony regarding his standard practices and charting methods, not the complaining patients' faulty memories and biased recitations.

A. Helena Nordstrom.

The Committee concluded that Dr. Chase discouraged Helena Nordstrom from receiving a second opinion and did not adequately explain her condition and symptoms to her. However, Ms. Nordstrom did not provide unbiased, reliable testimony regarding her interactions with Dr. Chase. Ms. Nordstrom demonstrated significant bias toward Dr. Chase during the hearing, spontaneously shouting at Dr. Chase about his purported inability to treat her mother's dry eye condition. Ms. Nordstrom also demonstrated significant unreliability as a witness, admitting on

many occasions that she had previously testified untruthfully while under oath and repeatedly contradicting her own sworn testimony. (PF ¶¶ 317-19.)

As just one of many examples, Ms. Nordstrom contradicted herself and her prior 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. (PF ¶¶ 320-21.) She then lied about receiving sample eye drops from Dr. Chase to remedy her ocular complaints. (PF ¶ 318.) In short, Ms. Nordstrom's testimony was not a sufficiently unbiased or reliable basis on which to find an experienced physician guilty of unprofessional conduct.

B. Judith Salatino.

The Committee found that Dr. Chase suggested to Ms. Salatino that a second opinion was unnecessary and that he did not properly counsel her on her symptoms. However, Ms. Salatino demonstrated the significant bias expected of a patient who filed a purported class-action lawsuit⁹ against Dr. Chase within a week of reading about his summary suspension and without ever receiving an expert opinion that her cataract surgery was unnecessary, as she now claims. Prior to her surgery, Ms. Salatino informed Dr. Chase's technicians on multiple occasions that she was having difficulty with symptoms of glare, particularly when driving at night. (FF ¶¶ 157-161; PF ¶¶ 329, 330, 332.) Immediately after Dr. Chase's license was suspended, but before she had sued Dr. Chase, Ms. Salatino confirmed to another ophthalmologist, Dr. Alan Irwin, that prior to her surgery she "had been having trouble with night driving and distance vision in general." (FF ¶ 181; PF ¶ 345.)

⁹ On Friday, August 31, 2007, the Vermont Supreme Court rejected Ms. Salatino's last-ditch attempt to have her lawsuit against Dr. Chase declared a class action. It remains to be seen whether she will pursue her claim now that her attorneys lack the significant monetary incentive that would have been provided by such a class action.

Three days later, on July 28, 2003, Ms. Salatino filed a lawsuit against Dr. Chase and his wife accusing them of fraud, malpractice, assault and battery, and intentional infliction of emotional distress. (FF ¶ 183; PF ¶ 349.) Just over a month later, Ms. Salatino was examined by the State’s expert, Dr. Patrick Morhun. She told Dr. Morhun that before the surgery she had not been having trouble with driving at night. (FF ¶ 186; PF ¶ 354.) That denial was directly contradicted by the medical records of both Dr. Chase and Dr. Irwin. (*Id.*) 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”. (*Id.*) At the hearing, she denied having problems with glare and night driving prior to her surgery.

In short, Ms. Salatino’s testimony amply demonstrated that she had both a motive to shade the truth, and had in fact given false testimony under oath on the issues most central to her allegations against Dr. Chase. In the face of this and other demonstrably false and mistaken testimony by Ms. Salatino, the Committee erred in mechanically declaring her to be a reliable witness on whose testimony Dr. Chase’s reputation and career should depend. The Board should decline to endorse the Committee’s finding that Dr. Chase discouraged Ms. Salatino from receiving a second opinion or any other adverse findings based on her testimony regarding the details of her interaction with Dr. Chase and his staff.

C. Susan Lang.

The Committee found that Dr. Chase directly told Susan Lang not to seek a second opinion regarding cataract surgery and did not thoroughly counsel her on her visual needs and treatment options. Ms. Lang is also part of the putative class action suit against Dr. Chase, in which she is seeking money damages from him. Until Ms. Lang read about Dr. Chase’s license suspension in the newspaper, she never felt mistreated by him. (PF ¶¶ 358-59.) Prior to her

cataract surgery, Ms. Lang repeatedly reported to Dr. Chase that she was having difficulty seeing. For instance, 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.” (PF ¶ 371.) Similarly during her June 30, 2003 examination, Ms. Lang updated her Eye Health History form with Dr. Chase’s technician. On that form, she indicated that she was “currently experiencing” halos and was “bothered by glare.” (FF ¶ 207; PF ¶ 376.) She also complained to Dr. Chase that she was having trouble seeing a small scientific instrument at her work. (FF ¶ 208; PF ¶ 377.) Nonetheless, at the merits hearing, Ms. Lang denied that she was experiencing the problems that she self-reported to Dr. Chase and his staff. Ms. Lang maintained that, in filling out her history forms, she did not intend to convey that she was actually experiencing 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. (PF ¶ 372.)

Ms. Lang’s testimony that she only intended to convey symptoms that she did not actually experience in real life was nonsensical and not credible. Her obvious bias and unwillingness to admit to her prior self-reported symptoms demonstrates that the Committee’s rote finding of credibility is unwarranted. The Board should not, on the basis of her testimony, find that she was not experiencing significant visual symptoms or that Dr. Chase discouraged her from receiving a second opinion.

D. Marilyn Grigas.

Ms. Grigas’ primary complaint against Dr. Chase was that he placed her on the surgical schedule the day after he recommended surgery to her and that she therefore felt rushed into surgery. Based on the overwhelming weight of the evidence, the Board rejected that allegation,

finding that Ms. Grigas was recommended cataract surgery on September 9, 2002, but was not scheduled for surgery until three weeks later, and only after completing the informed consent process with Dr. Chase's nurse, whom Ms. Grigas described as a "patient advocate." (FF ¶¶ 238-250.)

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

Simply put, the record reflects that Ms. Grigas expressed a certitude regarding her recollection of the details of the examination that was not justified by her actual ability to recall those details. (PF ¶ 417.) Dr. Chase does not question Ms. Grigas' honesty, but her recollection regarding the operative events is far too unreliable a basis on which to base any finding of unprofessional conduct by Dr. Chase. It is her recollection alone that forms the basis of the Committee's adverse findings. Those findings, including those regarding discussion of her symptoms and treatment options, should be disregarded by the Board.

E. Jane Corning.

Jane Corning's only complaint against Dr. Chase is that she felt rushed into cataract surgery because, according to her recollection, Dr. Chase urged her to undergo surgery on the Tuesday immediately following her Friday, June 30, 2000 office appointment.¹⁰ That Tuesday was July 4, 2000. Dr. Chase's records do not reflect that Ms. Corning was scheduled for surgery

¹⁰ Dr. Chase always performed cataract surgeries on Tuesdays.

on that date. Instead, Dr. Chase's office was closed on July 4, 2000 and no surgery was scheduled for that day. (FF ¶ 284; PF ¶ 448.) Moreover, at the hearing, Ms Corning conceded that she might have been mistaken in thinking Dr. Chase meant Tuesday, July 4th, rather than July 11th or 18th. (FF ¶ 284; PF ¶ 448.) In short, the evidence showed that Ms. Corning was understandably mistaken in her recollection of the details of events that occurred over seven years ago. Those facts formed the basis of her sole allegation against Dr. Chase. The Committee was wrong to declare as reliable her testimony as to those facts, or the even smaller details of her examination by Dr. Chase, such as his exact words to her. The Board should disregard all of the Committee's adverse factual findings based on Ms. Corning's testimony of her interactions with Dr. Chase.

F. Frank Cole.

The Committee also determined that Frank Cole reliably testified regarding the details of his treatment by Dr. Chase over 14 years ago. Mr. Cole filed a complaint with the Medical Practice Board alleging, among other things: (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. (PF ¶ 471.)

Mr. Cole was mistaken in his recollection regarding every one of these important events. As evidenced 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; (2) Mr. Cole often missed his appointments with Dr. Chase, and at times went two years without an examination; (3) Mr. Cole was diagnosed as having cataracts in both eyes by both Dr. Cleary and Dr. Maguire; and (4) Dr. Cleary failed to perform a comprehensive glaucoma evaluation and Dr. Maguire did not even examine Mr. Cole for the presence of glaucoma. (PF ¶ 472.)

Mr. Cole was also mistaken in his recollection of other important facts. For instance, 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. (PF ¶ 473.) Those same records demonstrate that Mr. Cole's cup-to-disc ratio had grown significantly since his last examination, demonstrating a clear progression of his glaucoma. (PF ¶ 94.) The Report ignores all of these uncontroverted facts.

In short, Mr. Cole's recollection of relevant events was completely off base. He consistently misremembered what all of his doctors told him, rendering unreliable his claim that Dr. Chase discouraged him from getting a second opinion, as well as his recollection that he had no problems with his vision. His testimony certainly does not provide a sufficient evidentiary basis for any finding that Dr. Chase acted unprofessionally in treating him over 14 years ago. It provides no basis on which to conclude that Mr. Cole was an improper candidate for cataract and glaucoma treatment. In fact, his records show that he suffered from both diseases, which went untreated by his subsequent eye doctors despite warning signs that he was losing his vision.

G. Margaret McGowan.

The Committee found that Dr. Chase told Margaret McGowan that no other physician was certified to perform her cataract surgery and that he and his staff did not properly counsel her regarding her surgery.

Dr. Chase first diagnosed Ms. McGowan with cataracts in 1997. He diagnosed her with cataracts on each subsequent visit in 1999, 2001, and 2003. 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. On each of those occasions, Ms. McGowan reported to Dr. Chase that she was seeing “starbursts” around oncoming headlights when driving at night. On each occasion, she told Dr. Chase that the starbursts “bothered her” when driving at night. (PF ¶¶ 503-05.) In 1997, 1999, and 2001, Ms. McGowan recalls telling Dr. Chase that she was not yet ready for surgery, and admits that Dr. Chase simply scheduled her for another appointment in two years, saying “When it bothers you enough, we’ll take care of it.” (PF ¶ 507.)

At the beginning of her examination in June 13, 2003, Ms. McGowan filled out an Eye Health History form, in which she indicated that she was “currently” being “bothered by glare.” On that same form, she indicated that she would “like more information about” “cataract surgery.” When filling out this same form two years earlier, Ms. McGowan had not indicated that she was bothered by glare or that she wanted more information about cataract surgery. At her June 13, 2003 examination, Ms. McGowan also completed a Lifestyle Questionnaire, on which she indicated that her sight “sometimes” made it a “problem” to see traffic signs, read newspapers, and work at her job, among other things. She also reported that she was sometimes “bothered by” poor night vision, glare, hazy or blurry vision, and seeing in poor or dim light. Finally, she reported that problems with her sight always caused her to be “fearful” when she

drove during evening or night hours. (PF ¶¶ 508-09.) Ms. McGowan ultimately had cataract surgery on her right eye.

Shortly after her surgery, Dr. Chase's license was suspended, and Ms. McGowan read about the suspension in the newspaper. Although she had received no medical opinion that her right eye surgery had been inappropriate, Ms. McGowan filed a lawsuit against Dr. Chase and his wife, seeking money damages for her "unnecessary" right eye cataract surgery. (PF ¶ 520.) Ms. McGowan now claims she was not suffering from any significant visual problems at the time of her surgery. She even told the State's expert, Dr. Morhun, that she was seeing fine and that her activities of daily living were not adversely affected by her vision. (PF ¶ 522.) Of course, these crucial allegations are directly contrary to Ms. McGowan's own prior written statements. In light of her significant monetary incentive to shade the truth, as well as her demonstrably false statements as to her central claims, Ms. McGowan's testimony cannot be deemed credible and the charges that rely on that testimony cannot stand.

H. William Augood.

The Committee found that Dr. Chase told Mr. Augood that there was "no point" in getting a second opinion and that he did not properly explain his vision and visual needs. Like all but one of the complaining witnesses, Mr. Augood did not file a complaint against Dr. Chase until after he read about the summary suspension in the newspaper, a year after he had been treated by Dr. Chase. Mr. Augood admitted numerous times during his sworn testimony that his memory of the relevant events of 2002 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.) He also attempted to disclaim much of

his prior sworn testimony from Dr. Chase's federal trial, stating that he had been unable to testify accurately because of the stress of the situation. (PF ¶¶ 581-84.) During his testimony, Mr. Augood amply displayed his inability to concentrate, (PF ¶ 584), further calling into question his ability to recall what Dr. Chase told him about the possibility of surgery. If Mr. Augood now admits to testifying inaccurately under oath in federal court, and is admittedly unable to recall much of his examination, his testimony regarding the same subjects cannot now be relied upon to sanction Dr. Chase for unprofessional conduct or to establish the specifics of what Dr. Chase told him about second opinions. The Committee was wrong to unquestioningly accept his account as true.

I. Jan Kerr.

The Committee concluded that Jan Kerr's recollection of the details of her examination is a sufficient basis on which to find that Dr. Chase informed her that a second opinion was not necessary and that he was the most qualified doctor to perform her operation. However, Ms. Kerr herself admitted that she was not paying much attention to what Dr. Chase said because she was worried about the cataracts and what she was going to do about them. (PF ¶ 597.) As noted above, many patients find it difficult to absorb what their physician is telling them immediately after a surgery recommendation, even if they are listening closely. That is why Dr. Chase's nurses reiterated important information to his patients. While Ms. Kerr may now feel that Dr. Chase discouraged her from getting a second opinion, that fact is not a reliable indication of what Dr. Chase told her. It was improper for the Committee's to rely on Ms. Kerr's admittedly poor memory in the face of Dr. Chase's sworn testimony as to what he routinely told, and did not tell, patients about second opinions.

VIII. The Committee Report Improperly Includes Findings Regarding Dr. Chase's General Pattern And Practice, Even Though The State Dropped Those Charges And Dr. Chase Was Prevented From Presenting His Statistical Evidence.

Prior to the merits hearing, the State dropped all charges that Dr. Chase had engaged in a pattern and practice of unprofessional conduct, focusing its charges only on the 11 complaining patients. It dismissed the pattern and practice charges in a successful attempt to preclude Dr. Chase from introducing extensive and critical exculpatory evidence. The excluded evidence included Respondent's summary charts analyzing key characteristics of Dr. Chase's cataract and cataract surgery patients during specified periods. Nonetheless, during the hearing and in its post-hearing submissions, the State relied upon the very pattern and practice argument that it expressly promised it would not make, buttressing the testimonial claims of one patient by arguing that the remaining ten State patient witnesses had the same experience, are making the same claim, and that the truth of the complaints is evinced by their number and similarity. *See* V.R.E. 404. In its Report, the Committee endorses this approach.

Even if the eleven patient witnesses' contentions were accurate and similar, which they are not, they would represent only the isolated perspectives of a few handpicked witnesses that the State culled from a truly huge number of patients treated by Dr. Chase during the eleven year period embraced by this case. The State's three surgical patients and eight nonsurgical patients were selected from patients Dr. Chase saw between 1992 and 2003. During that period he performed 250 to 300 cataract surgeries annually (2,500 to 3,000 total), treated an even greater number of cataract patients non-surgically, and had approximately 80,000 patient encounters. Dr. Chase attempted to introduce statistical evidence in order to provide important context to the State's isolated claims, but the State successfully prevented its introduction. It seems self evident that if Dr. Chase's patterns and practices are to be examined, they should be examined

against a broader and more objectively selected sampling of patients than the eleven complaining witnesses selected by the State. The Board must either reject the State's pattern and practice argument, and the Committee's endorsement of that position, or allow Dr. Chase to present all of his countervailing statistical evidence.

IX. The Committee Report Improperly Ignores Many Of Dr. Chase's Proposed Findings.

At the conclusion of the merits hearing, Dr. Chase submitted his Proposed Findings of Fact and Conclusions of Law. The purpose of findings of fact and conclusions of law is to make a clear statement, both to the litigants and to the Supreme Court if an appeal is taken, of what was decided and how the decision was reached. *Louis Anthony Corp. v. Department of Liquor Control*, 139 Vt. 570 (1981). As a result, pursuant to 3 V.S.A. § 812(a), the Board's final decision must "include a ruling on each proposed finding." *Id.* In drafting its Report, the Committee accepted many of Dr. Chase's proposed findings. It explicitly rejected others, adopting a different view of the evidence than that proposed by Dr. Chase. However, as to a large number of Dr. Chase's proposed findings, the Board neither accepted nor rejected them. Instead, it simply omitted them from the Report without mention. For instance, as discussed above, it omitted any reference to the Beaver Dam Study and its unimpeachable conclusions. Pursuant to section 812(a), those omissions constitute legal error. Each of the omitted findings is strongly supported by the evidence and the law and, as a result, must be included in the Board's final decision.

X. The Committee's Factual Findings With Respect To Individual Patients Are Not Supported By The Record.

The Committee's Report deviates from Dr. Chase's Proposed Findings of Fact in a number of instances relating to the care of individual patients. For the reasons set forth in Dr.

Chase's post-hearing submissions, he takes exception to each finding that does not conform to his Proposed Findings of Fact and Conclusions of Law. All of Dr. Chase's proposed findings are strongly supported by the preponderance of the record evidence, and the State failed to meet its burden of proving them to be false. Rather than repeat all of his exceptions at length here, Dr. Chase incorporates his Post Trial Brief, Post-Trial Rebuttal Brief, and his Proposed Findings of Fact and Conclusions of Law herein. One example, however, illustrates how strongly the record supports Dr. Chase's diagnosis and treatment decisions.

Dr. Chase offered cataract surgery to Joseph Touchette to remedy his blurry vision. The Report suggests, without deciding, that Dr. Watson was correct in his determination that Mr. Touchette's vision problems were not due to his cataracts. The evidence does not support this conclusion. As the Committee properly found, there was no change in Mr. Touchette's glasses prescription that would account for his vision problems. (FF ¶ 359.) His CST with BAT scores, measured with his best possible correction, showed a significant deficit. (FF ¶ 360.) Dr. Watson confirmed that Mr. Touchette had cataracts. (FF ¶ 373.) Dr. Watson was unable to provide a lasting remedy for Mr. Touchette's vision problems by altering his glasses, and provided no other explanation for Mr. Touchette's recurring blurry vision. (PF ¶¶ 556-561.) The State's evidence, therefore, provides no ground on which to reject Dr. Chase's proposed finding, and his sworn expert testimony, that no glasses would correct Mr. Touchette's visual defects, which could have been addressed through surgery if Mr. Touchette so chose. (PF ¶ 560.)

XI. The Committee Impermissibly Placed The Burden Of Proof On Dr. Chase.

The State bears the burden of proving all of its factual allegations and legal charges by a preponderance of the evidence. *See Huddleston v. University of Vermont*, 168 Vt. 249, 252 (1998). Dr. Chase, in turn, has no obligation to prove his innocence, or to disprove any of the

State's allegations. As a result, if the State failed to introduce evidence in support of its charges, the Committee and the Board are bound to reject them. Throughout its Report, the Committee turns this burden of proof on its head.

For instance, as discussed at length above, it is the State's burden to demonstrate, through competent evidence, that there exists a medical standard preventing ophthalmologists from describing visually significant cataracts as "dense." It is similarly the State's obligation to introduce evidence of its invented "collaborative process" standard. It is not Dr. Chase's obligation to demonstrate that his practices—whether they relate to cataract descriptions or informed consent—were the norm among ophthalmologists. Although the State introduced no evidence of either of these standards of care, the Report recommends that the Board find against Dr. Chase with respect to both practices. In so doing, it disregards the burden of proof.

That disregard is also highlighted by the Committee's conclusions regarding Ms. Nordstrom's cataracts and poor vision. Ms. Nordstrom came to Dr. Chase complaining of blurry distance vision for approximately three weeks and difficulty seeing clearly to drive at night, among other things. (FF ¶¶ 119-121; PF ¶¶ 267, 269-72.) When she viewed the Snellen chart in Dr. Chase's office, she performed poorly, both as measured by the autorefractor, the technician, and by Dr. Chase himself. (FF ¶ 122; PF ¶ 271.) Even Ms. Nordstrom testified that when her vision was tested prior to dilation, the Snellen chart was blurry. (FF ¶ 123; PF ¶ 272.) The measurements taken by Dr. Chase's technicians showed that there had been no change in her glasses prescription that would account for her symptoms. (FF ¶ 124; PF ¶ 273.)

Dr. Chase's January 2003 examination revealed that Ms. Nordstrom was suffering from cataracts, which were causing her vision problems. (PF ¶ 274.) Despite performing an exhaustive examination, including an Amsler grid test—yet another test performed by none of

the other testifying physicians with respect to any of the complaining patients—he found no other condition that might account for her symptoms. (PF ¶ 276.) Dr. Freeman, who examined the charts maintained by both Dr. Chase and Dr. Morhun, agreed that there was no cause other than cataracts for Ms. Nordstrom’s visual symptoms. (PF ¶ 277.)

However, prior to performing cataract surgery on Ms. Nordstrom, Dr. Chase ordered her to get 2-hour blood sugar and CBC test. (FF ¶ 132; PF ¶ 280.) Her surgery was contingent upon the results. (PF ¶¶ 280-81.) Dr. Chase testified that he did this in order to determine if her cataracts were caused by fluctuating blood sugar levels, which can cause transitory cataracts that disappear as sugar levels stabilize. (PF ¶ 281.) As always, he was concerned with his patients’ entire health, not just their eyes.

The State’s ophthalmologists agree that fluctuating blood sugar levels can cause transitory cataracts, sometimes referred to as water clefts. (PF ¶ 284.) In fact, since many diabetics go undiagnosed, and diabetes can significantly affect patients’ ocular health, ophthalmologists are often the first physicians to notice the signs of early diabetes in their patients. Dr. Morhun acknowledged that the only reason an ophthalmologist might order a patient to have a blood sugar test is concern that a patient’s glucose intolerance is affecting her vision and to detect incipient diabetes, further bolstering Dr. Chase’s explanation. (PF ¶ 282.) Ms. Nordstrom declined to get the blood sugar test Dr. Chase had ordered and did not go forward with surgery. (PF ¶ 290.) Indeed, she has never gotten a blood sugar test, and has never been evaluated for glucose intolerance or diabetes. She testified that her distance vision nonetheless improved over the coming months—a fact that she attributed to new glasses.

Dr. Morhun found no cataract when he examined Ms. Nordstrom five months later in June 2003. (PF ¶ 299.) By that time, her Snellen vision had greatly improved. Dr. Morhun

confirmed, however, that her vision did not improve due to new glasses. (PF ¶ 300.) Her prescription had not changed. Indeed, based on his examination, Dr. Morhun could not find any reason for Ms. Nordstrom's radically improved vision. (FF ¶ 148; PF ¶ 301.) He admitted that, based on all of the evidence, he could no longer rule out a transitory cataract as the cause of Ms. Nordstrom's problems. (PF ¶ 307.)

Although the State bore the burden of proof, it offered absolutely no explanation for Ms. Nordstrom's case, much less any evidence to support an explanation. Because Ms. Nordstrom refused to get a blood test, has never been evaluated for diabetes, and refused to be examined by Dr. Chase's experts, the State introduced no evidence that Ms. Nordstrom was, or was not, diabetic. Instead, the State attempted to shift the burden to Dr. Chase to prove that her change in vision was not indicative of unprofessional conduct on his part.

Although it was not his obligation to do so, Dr. Chase offered the only two plausible explanations for Ms. Nordstrom's case: Dr. Morhun either failed to see Ms. Nordstrom's cataract or it was transient. Both explanations find strong support in the record evidence and the Committee's own findings, which demonstrate that Ms. Nordstrom falsely denied any past visual symptoms to Dr. Morhun, thereby giving him no reason to look for a cataract, particularly a water cleft cataract that would be difficult to observe. The same evidence showed that, in performing his examination, Dr. Morhun failed to perform retroillumination with a direct ophthalmoscope. (FF ¶ 146.) The Committee found that such retroillumination is often necessary to observe water clefts, because they are not easily discernable through a slit lamp. (FF ¶ 40.) In contrast, Dr. Chase performed retroillumination and ordered Ms. Nordstrom to receive a blood test because he was suspicious of a blood sugar problem given the appearance of her cataracts. Finally, Dr. Morhun's testimony demonstrated that he failed to notice many other cataracts

diagnosed by other ophthalmologists called by the State as witnesses, (PF ¶ 309), and exhibited a lack of care when reviewing Dr. Chase's charts for the Board's investigator. (PF ¶ 310.)

Despite the State's complete failure to satisfy its burden of proof, the Committee accepted portions of the State's allegations and rejected Dr. Chase's hypothesis:

Several explanations concerning the possible causes of the vision problems Ms. Nordstrom reported on January 17, 2003, were suggested by Respondent. It was suggested that Ms. Nordstrom may have been diabetic. The evidence does not support that Ms. Nordstrom has ever been diabetic. She is not diabetic. It was also suggested that Ms. Nordstrom had fluctuating blood sugar levels at the time of Respondent's examination of her. The evidence does not support that conclusion.

The contention that fluctuating blood sugar levels caused water clefts, or transitory cataracts, in Ms. Nordstrom's eyes on January 17, 2003, is not supported by the evidence. The contention that Respondent saw and diagnosed water clefts in Ms. Nordstrom's eyes and those water clefts then disappeared and were not present during subsequent examinations of Ms. Nordstrom's eyes is not supported by the evidence, is not credible, and is rejected by the Committee.

(FF ¶¶ 136-137.) In so doing, the Committee turned the burden of proof on its head, even going so far as to declare Ms. Nordstrom free of diabetes, despite any evidence to that effect. It was the State's burden to prove that Dr. Chase acted unprofessionally. It was not his burden to explain Ms. Nordstrom's case, four years later and without her cooperation. The Board must hold the State to its burden on this and all other matters.

XII. The Committee Did Not Consider Or Decide Dr. Chase's Motion To Dismiss.

During cross-examination of the State's main expert, Dr. Patrick Morhun, it became clear that both he and the State have been aware since 2004 that the expert opinions on which Dr. Chase's summary suspension was based, and his career was ended, were fundamentally mistaken in a number of ways. Nonetheless, neither Dr. Morhun nor the State revealed those mistakes to the Board, and instead actively attempted to hide their errors. Because the State and its experts

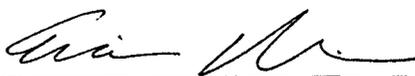
breached their duty of candor to this tribunal, Dr. Chase asked the Board to dismiss the charges against him as part of his December 15, 2006 Motion for Judgment. The Committee never ruled upon that request. As part of its judgment in this case, the Board must entertain and rule upon Dr. Chase's request for dismissal, which is incorporated herein.

XIII. Conclusion.

For all of the reasons stated above, the Board should adopt the Committee's findings that Dr. Chase did not engage in unprofessional conduct. The Board should respectfully decline to adopt any findings that Dr. Chase engaged in unprofessional conduct because those findings are contrary to law and to the record evidence. The Board should adopt all of Dr. Chase's Proposed Findings of Fact and Conclusions Of Law and bring the State's ill-conceived prosecution of Dr. Chase to an end.

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

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