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Vermont Board of
Medical Practice

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In Re:	)	
DAVID S. CHASE, M.D.	)	Docket No. MPC 15-0203, et al.
Respondent	)	

BOARD: Sharon L. Nicol, Public Member
Alexander Northern, Public Member
James D. Cahill, M.D., Physician Member
Toby Sadkin, M.D., Physician Member
Hon. Hilton H. Dier, Jr., Ad Hoc Member

PRESIDING OFFICER: Phillip J. Cykon, Esq.

APPEARANCES: Joseph Winn, Esq.; Assistant Attorney General
Michael Duane, Esq.; Assistant Attorney General
Eric S. Miller, Esq. Counsel for Respondent,
David S. Chase, M.D.

THE BOARD'S RULINGS ON THE PARTIES' EXCEPTIONS TO THE HEARING COMMITTEE REPORT

and

FINDINGS OF FACT, CONCLUSIONS OF LAW, JUDGMENT, AND ORDER OF THE BOARD ON THE CHARGES OF UNPROFESSIONAL CONDUCT

BACKGROUND

On September 11, 2006, the Hearing Committee (Committee) of the Vermont Board of Medical Practice (Board) began the contested administrative hearing on the Amended Specification of Charges dated May 13, 2005, and filed by the Vermont Attorney General's Office against David S. Chase, M.D. (Respondent). Subsequent hearing days were held on September 12, 21, 25, 26; October 2, 3, 23, 24, 26; November 8, 20, 30; December 4, 18 of 2006; and January 4, 8, 9, 30; February 8 of 2007. During the hearing, the Committee heard extensive testimony by both fact witnesses and expert witnesses and received numerous exhibits offered by both the State and the Respondent. Both sides presented closing statements at the end of the hearing. The Committee listened carefully and was afforded the opportunity to ask questions of the witnesses, including the Respondent. The parties submitted extensive proposed findings and memoranda in support. During their deliberations, the Committee did a significant amount of work reviewing the testimony and evidence admitted at the hearing. Upon consideration and deliberation of the above-stated material, the Committee reported its Findings of Fact, Conclusions of Law, and Proposed Decision to the Board pursuant to 26 V.S.A. § 1355(b).

The Hearing Committee Report was served upon the parties to this matter, and in accordance with 3 V.S.A. § 811, each party adversely affected had the opportunity to file exceptions, and present briefs and oral arguments to the Board. Respondent filed "Respondent's Exceptions to the Hearing Committee Report" and Memorandum dated 9/7/07 and "Respondent's Reply Memorandum to the State's Request to Amend the Hearing Committee Report" dated 10/5/07. The State filed "State of Vermont's Request to Amend Report of Hearing Committee" and Memorandum in Support dated 9/7/07 and "Response of State of Vermont to Respondent's Exceptions" dated 10/5/07.

Oral arguments were presented by the parties to the Board on November 7, 2007. At the close of arguments, the Board went into deliberative session to consider the record of evidence and the above-stated material and deliberate on the pending matter.

RULINGS ON RESPONDENT'S EXCEPTIONS

The Board rules on Respondent's exceptions as they have been generally raised in his Memorandum that accompanied "Respondent's Exceptions to the Hearing Committee Report".

1. Respondent takes exception to the Hearing Committee's findings and conclusions recommending that the Board find him in violation of 26 V.S.A. §§ 1354(a)(22) and 1354(b), contending that the standard imposed under these subsections was not met by the State's evidence. After review and deliberation, the Board disagrees with Respondent. The conclusions that Respondent engaged in unprofessional conduct under 26 V.S.A. §§ 1354(a)(22) and 1354(b) are supported by the evidence and the facts as found by the Committee. It appears from the record that the Committee applied the relevant "reasonableness standard" to the facts and determined that Respondent's conduct violated the statute. See *Braun v. Board of Dental Examiners*, 167 Vt. 110, 114 (1997). In support of its conclusions that Respondent violated 26 V.S.A. § 1354(a)(22) regarding several patients, the Committee found that Respondent's use of the term "dense" to describe certain cataracts, his failure to adequately discuss with patients whether their vision was meeting their needs or whether it was compromising their lives, and his practice regarding giving second opinions constituted gross failures to exercise the proper standard of care in those instances. Respondent's contention that the statute only proscribes "heedless" violations is rejected.

2. Respondent's contention that 26 V.S.A. § 1354(b) is unconstitutionally vague is also rejected. In order for a statute to comply with this constitutional standard, it does not have to detail each and every act that is prohibited. It is constitutionally sufficient if the language conveys a definite warning as to what conduct is unlawful when measured by common understanding and practices. *Brody v. Barasch*, 155 Vt. 103, 111 (1990). The evidence, including the expert testimony and the AAO Preferred Practice Patterns, established reasonable standards by which the statutory proscription can be applied.

3. Respondent contends that his descriptions of the cataracts present in the lenses of the patients' eyes as "dense" was appropriate and does not constitute unprofessional conduct as found and concluded by the Hearing Committee. The evidence did show that physicians differ in the way that they describe or rate cataracts, and that there is disagreement on the grading of cataracts, as the Committee found. However, based upon the testimony of the experts and the

AAO Preferred Practice Patterns, the Committee found cataracts described as "dense" have characteristics such opalescence, brunescence, or blackness; are mature and opaque and allow little or no light to pass through them; and are more clinically significant than cataracts described as "early" or "trace". For every patient, except Mr. Olson, subsequent eye examinations contradicted Respondent's description of dense cataracts. Respondent's use of dense to describe the patients' cataracts did not conform to the understanding of what that term means as established by the expert testimony and the AAO Preferred Practice Patterns. While the Committee did not find Respondent's description of the cataracts as dense to be deliberately false, the Committee concluded that this inaccurate description in each of the cases was a gross departure from the standard of care and a failure to practice competently. The Board accepts the Committee's findings and conclusions in this regard.

4. The record does not establish that Dr. Brown, Ad Hoc Hearing Committee member, had prejudged anything or was in any manner biased against Respondent. Respondent has not "made any showing of actual bias or prejudgment on the part of" Dr. Brown, to "overcome the presumption of honesty and integrity that attaches to the actions of the panel members as adjudicators." *Brody v. Barasch*, 155 Vt. 103, 110 (1990). During the evidentiary hearing, Respondent noted his concern regarding Dr. Brown, but never raised a formal objection or motion to disqualify, and did not accept an offer to conduct a voir dire examination of Dr. Brown or any of the other Committee members.

5. Respondent contends that the Committee's findings and conclusions of unprofessional conduct regarding Respondent's communication with his patients are factually and legally deficient. Respondent claims that the State failed to sufficiently charge the lack of meaningful communication between he and his patients. First of all, notice is considered to satisfy due process "if it fairly apprises the person of the nature of the charges so he may prepare for the hearing and defend his position." *Braun v. Board of Dental Examiners*, 167 Vt. 110, 117 (1997). The Amended Specification of Charges are filled with alleged facts about patients feeling uncomfortable, confused, and pressured; patients feeling that they did not have time to discuss why there was an urgent need for cataract surgery; confusion about second opinions; notations in medical charts based on statements that patients claimed they did not make; and more. These allegations put Respondent on notice that contact and communication between him and his patients was at issue. Respondent vigorously defended those issues by introducing relevant evidence and cross-examining patient witnesses along those lines. Notice to Respondent was legally sufficient. The issue of patient-physician communication was noticed, in part, by allegations that entries indicating that a patient stated that cataracts interfered with his life and that he wanted cataract surgery were false. While the Hearing Committee did not find that the notations were deliberate falsehoods, the Committee did find that the notations were evidence that corroborated other evidence that Respondent failed to engage in meaningful discussion with his patients concerning crucial details. For these reasons, the evidence supports the Committee's factual findings regarding Respondent's failure to discuss with his patients important information about the condition of their eyes and how that condition is affecting their lives. Furthermore, while staff may have been very attentive to the patients, staff could not properly discuss whether the patient's vision was meeting his or her needs, the extent to which vision may be compromising their lives, or whether glasses or other treatment might be an alternative to surgery. In these situations, the Committee properly found that such discussions with the patients were Respondent's responsibility. These findings are factually sufficient to support the conclusions that Respondent engaged in unprofessional conduct as charged.

6. Respondent claims that the Committee erred in excluding Brianne Chase and Ellen Flanagan from testifying regarding counseling performed by Respondent's staff and second opinions. The Committee listened to the proffer regarding the testimony of these witnesses. While these witnesses could offer general testimony about office operations, they could not testify specifically concerning any of the patients whose treatment is at issue in this case. Furthermore, the Committee heard testimony from several of Respondent's former patients not involved in this case regarding how they were favorably treated by Respondent and his staff. The Board accepts the ruling of the Hearing Committee.

7. Respondent claims that his second opinion explanation to his patients was not unprofessional conduct. The Hearing Committee found that Respondent's statements to his patients regarding second opinions were confusing, misleading, and improper. The allegations contained in the Amended Specification of Charges provided sufficient notice to Respondent that his second opinion statements were at issue. He vigorously explained and defended the second opinion statements he made to patients. The Hearing Committee, after hearing all the witnesses and receiving the evidence relevant to Respondent's second opinion statements, specifically found that there was conflicting evidence about these statements, and that Respondent's explanation concerning his statements, to specific patients and in general, was simply not credible. The Committee found that this conduct constituted unprofessional conduct in several instances under 26 V.S.A. §§ 1354(a)(22) and 1354(b). The Board accepts the Committee's determination of credibility and its conclusions regarding unprofessional conduct under 26 V.S.A. §§ 1354(a)(22) and 1354(b).

8. Respondent contends that the Committee did not perform a meaningful analysis of each patient's credibility. The Board disagrees. During numerous days of hearings, the Committee listened to and observed each witness testify. Respondent had the opportunity to cross-examine each witness at length concerning previous statements and testimony. The Committee was able to compare witness testimony to information contained in medical records. Based on all of this, the Committee made specific findings as to the credibility of each witness. The Board accepts these findings.

9. The Board disagrees with Respondent's contention that the Committee made findings of general pattern and practice. While there are similarities in the way Respondent dealt with his patients, the findings and conclusions were made after separately considering the relevant evidence as it pertained to each allegation contained in the Amended Specification of Charges. Each conclusion of unprofessional conduct is supported by separate findings of fact and can stand on its own without any consideration of general pattern and practice.

10. Respondent claims that the Committee Report fails to address some of Respondent's proposed findings. As the Vermont Supreme Court has stated:

> The purpose of findings of fact and conclusions of law, as required by 3 V.S.A. § 812, is to make a clear statement to the litigants, and to this 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, 573 (1981). The Committee detailed 418 specific findings of fact to support 110 conclusions of law to state how it has arrived at its proposal for decision. The Board believes the Hearing Committee's Report complies with

the Court's above-stated purpose and, as the Court has also stated, "has left no doubt as to what it decided and how its decision was reached, thus fulfilling the purpose of findings of fact and conclusions of law." *In re Village of Hardwick Electric Dept.*, 143 Vt. 437, 445 (1983). The Board denies Respondent's objection in this regard.

11. The Board further denies Respondent's exception that factual findings with respect to individual patients are not supported by the record. Rather, the Board finds that the Committee's findings and conclusions are well-detailed and are supported by the evidence submitted at the hearings. Furthermore, the Committee and the Board recognize that the State at all times bears the burden of proving its allegations and charges by a preponderance of the evidence, and the Committee has adhered to and the Board will continue to adhere to this standard. The Board accepts the Committee's findings and conclusions in that regard.

12. Respondent has renewed his motion to dismiss on the ground of misconduct by the State. Respondent contends that the entire case should be dismissed, because of mistakes made by the Board Investigator, by the Assistant Attorney General, and the State's expert witness, Dr. Morhun. Respondent further contends that these errors were compounded by the failure of the State to acknowledge these mistakes. Respondent contends that the cumulative effect of these irregularities has denied him his constitutional right of due process. These issues had been raised several times via pre-hearing motions, and the Board had denied the motions each time. As it had before, the Board has considered each issue that Respondent has raised in this regard. At the hearing on the merits, Respondent was able to cross-examine Dr. Morhun regarding the irregularities at issue. Indeed, the Hearing Committee made findings as to the matters that Dr. Morhun overlooked and the shortcomings of his contact with Ms. Nordstrom. The Committee further found that Dr. Morhun, despite his admitted shortcomings, remained steadfast regarding his opinion of the condition of the lenses of the patient's eyes. The Board accepts the Committee's findings and conclusions in this regard. While the evidence certainly indicates that mistakes were made, the evidence does not establish that the State was intentionally falsifying evidence or perpetrating a fraud upon the Board. Having reviewed the grounds of Respondent's renewed motion to dismiss and the record before it, the Board concludes that the evidence does not support Respondent's motion to dismiss and it is therefore denied.

RULINGS ON STATE OF VERMONT'S REQUEST TO AMEND REPORT OF HEARING COMMITTEE

The State requests amendments to the Report in three general categories. The Board addresses those general categories in the order that the State raises them.

1. The State first takes exception to the Committee's conclusions that Respondent's entries present in the patients' medical records that are at issue were inaccuracies, misunderstandings, or overstatements. The State contends that the Board should conclude from the Committee's findings that Respondent's falsification of patient medical records constitutes willfully making and filing false reports in his practice as a physician in violation of 26 V.S.A. § 1354(a)(8). On that basis, the State requests the Board to amend its conclusions regarding Counts VI, XVIII, XXXI, XLIII, LVIII, LXXV, LXXXIV, XCIII, CII, and CXIII. The Committee, applying the preponderance of the evidence standard, declined to make the inference from the evidence that Respondent was willfully and deliberately falsifying records and filing false reports as contemplated by this statute. Instead, the Committee found that the entries were incorrect as a

result of Respondent's missteps other than purposeful falsification, and concluded that they did not constitute unprofessional conduct under this particular section of the statute. The Board, after review and deliberation, accepts the Hearing Committee's findings and conclusions and denies the State's request as to Counts VI, XVIII, XXXI, XLIII, LVIII, LXXV, LXXXIV, XCIII, CII, and CXIII.

2. The State next takes exception to the Committee's conclusions regarding the counts pertaining to Respondent's entries recommending cataract surgery, his entries that support those recommendations, his diagnosis of glaucoma, and his insistence on cataract surgery without discussing alternatives. The State contends that the Committee's findings indicate that Respondent's conduct as alleged in those counts does constitute dishonest (or dishonorable) or immoral conduct in violation of 26 V.S.A. § 1398. On that basis, the State requests the Board to amend Counts VII, IX, XIX, XXI, XXXII, XXXIV, XLIV, XLVI, LIX, LX, LXXVI, LXXVII, LXXVIII, LXXXV, LXXXVII, XCIV, XCV, CIII, CXIV, and CV to reflect the conclusion that Respondent's conduct constitutes unprofessional conduct under those counts. While the Committee obviously had concerns about Respondent's diagnosis of cataract formation, accompanying recommendations for surgery, and corresponding entries, it concluded that Respondent's conduct would be best addressed as unprofessional conduct under other statutes. The Board, after review and deliberation, accepts the Hearing Committee's findings and conclusions and denies the State's request as to Counts VII, IX, XIX, XXI, XXXII, XXXIV, XLIV, XLVI, LIX, LX, LXXVI, LXXVII, LXXVIII, LXXXV, LXXXVII, XCIV, XCV, CIII, CXIV, and CV.

The State also takes exception to the Committee's conclusions regarding Counts VIII, XXXVI, CVI, and CXV. These counts allege that Respondent directed patients not to seek a second opinion or attempted to discourage patients from obtaining a second opinion. The State charged in these counts that this conduct constitutes immoral, unprofessional, or dishonest conduct in violation of 26 V.S.A. § 1398. The Board notes that the counts charged by the State contain the word "dishonest" instead of the statutory language "dishonorable". The Committee concluded in these counts that Respondent's conduct involving his second opinion statements to patients was unprofessional conduct that fell under 26 V.S.A. §§ 1354(a)(22) and 1354(b) and would be addressed under those sections rather than section 1398. The Committee further concluded that Respondent's conduct alleged under these counts was not immoral or dishonest.

After review and deliberation, the Board disagrees with the Committee's conclusions that this conduct alleged in Counts VIII, XXXVI, CVI, and CXV does not constitute immoral, or as the statute specifically states, dishonorable conduct. The Committee made several specific findings of fact concerning Respondent's second opinion statements and related notations in the patients' medical charts. Although the Committee did not find that a preponderance of the evidence established these statements and notations to be willful and deliberate falsifications, the Committee did find that the statements to patients were misleading, confusing, and improper. The Board agrees with these findings, and based on the Committee's findings, after review and deliberation, concludes that Respondent's conduct in this regard does constitute a violation of 26 V.S.A. § 1398. This statute, as the Committee concluded, does set forth a different category of unprofessional conduct and thus serves a different purpose than 26 V.S.A. §§ 1354(a)(22) and 1354(b). Section 1398 determines "the personal and moral standards of those persons who may hold a license". *Delozier v. State*, 160 Vt. 426, 433 (1993). The Board concludes that Respondent's conduct regarding the second opinion statements he gave to his patients falls into the statutory purpose of section 1398. The Board agrees that his statements were confusing,

misleading, and improper, and were made at a time when patients were vulnerable and concerned about their eyes. For these reasons, the Board concludes that Respondent's conduct in this regard fell below the personal and moral standard required of a physician and constituted unprofessional conduct under 26 V.S.A. § 1398. The Board rejects the Hearing Committee's conclusions as to Counts VIII, XXXVI, CVI, and CXV and modifies those counts to reflect the Board's conclusion as stated in this paragraph.

3. Lastly, the State takes exception to the Committee's conclusion that the evidence does not support the allegations in Counts XX, XXXIII, and LXXXVI that Respondent performed unnecessary cataract surgery on patients. The Committee, applying the preponderance of the evidence standard, found that there was insufficient evidence that the cataract surgery was unnecessary, and concluded that there were no violations under those counts. These charges involve the respective patients' eyes on which Respondent had operated. Whatever was or was not present in those patients' lenses before the operation cannot be determined by subsequent examinations of those lenses. Furthermore, the subsequent examinations of the patients' lenses on which there had been no operation cannot establish what was present in the lenses that had been operated on. Without such evidence, Respondent's conduct concerning whether the patient's vision was meeting his or her needs, the extent to which vision may be compromising their lives, whether glasses or other treatment might be an alternative to surgery, and lack of collaborative discussion with patients, does not support the conclusion that the surgeries were unnecessary. After review and deliberation, the Board accepts the Committee's findings and conclusions and denies the State's request as to Counts XX, XXXIII, and LXXXVI.

FINDINGS OF FACT, CONCLUSIONS OF LAW, JUDGMENT, AND ORDER OF THE BOARD ON THE CHARGES OF UNPROFESSIONAL CONDUCT

Having ruled on Respondent's and the State's Exceptions to the Hearing Committee Report, the Board, pursuant to 26 V.S.A. §§ 1355(b) and 1360(a), accepts the findings and conclusions contained in the Hearing Committee Report except for the specific rejections and modifications regarding Counts VIII, XXXVI, CVI, and CXV. For the sake of clarity in the record, the Board hereby incorporates the Hearing Committee Report in its entirety. The Board modifies the Hearing Committee Report regarding Counts VIII, XXXVI, CVI, and CXV, and with those modifications, the Board accepts and issues the Findings of Fact and Conclusions of Law as set forth below. Based on the evidence in the record and the resulting Findings of Fact and Conclusions of Law, the Board renders its Judgment and Order on the charges of unprofessional conduct.

FINDINGS OF FACT

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

2. Dr. Chase is an ophthalmologist. He was raised in Littleton, New Hampshire by his mother, a schoolteacher.

3. Respondent graduated from the University of Vermont Medical School in 1962 and

completed his medical internship at the New York Upstate Medical Center in Syracuse in 1963. Dr. Chase then volunteered for the United States Navy, where he practiced general internal medicine for two years. He completed his three-year ophthalmology residency at the University of Indiana in 1968.

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

5. Respondent had a general ophthalmology practice specializing in cataract surgery. Dr. Chase generally saw about 30 patients per day and performed 250-300 cataract surgeries annually. This was comparable to the practice patterns of other general ophthalmologists in Vermont who specialized in cataract surgeries.

VISION

6. Vision, or visual function, has been described as having multiple components, including distance visual acuity, contrast sensitivity, and peripheral vision, among others.

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

8. Snellen visual acuity does not measure contrast sensitivity, which provides the patient with the ability to discern objects of varying contrast, luminance, and spatial frequency. Contrast sensitivity provides persons with the ability to perceive the edges of both large and small objects, and to distinguish them from their surroundings or background.

9. Visual function plays an important role in physical function, particularly in terms of mobility. Having blurred vision more than once or twice a month may have a significant impact on functional status, interfering with work or other daily activities.

10. The loss of visual function in the elderly may cause a decline in physical and mental functioning, as well as independence in activities of daily living, including night-time driving, daytime driving, community activities, and home activities.

CATARACTS

11. The American Academy of Ophthalmology Preferred Practice Pattern (AAO PPP) is a series of guidelines that identify characteristics and components of quality eye care. Exhibit

503B is one such guideline entitled Cataract in the Adult Eye. It is intended to and does provide guidance for the pattern of practice regarding treatment and care of cataracts.

12. A cataract is a degradation of the optical quality of the crystalline lens of the eye through loss of clarity or change in color.

13. The two lenses of the eye are the cornea and the crystalline lens. About one-third of the eye's refractive power is in the lens and the remainder is in the cornea; but the lens' ability to

flex, or change shape, permits persons to change focus to see near objects sharply.

14. The crystalline lens of the eye is composed of three concentric layers: (a) the nucleus of the lens is at the very center of the lens; (b) the cortex of the lens surrounds the nucleus on all sides; (c) the capsule of the lens is a thin membrane that surrounds the cortex on all sides.

15. Cataracts can occur in any of these three portions of the lens, and are therefore referred to as nuclear cataracts, cortical cataracts, and posterior subcapsular cataracts. Each type has its own anatomical location, pathology, and risk factors for development. Several systems are available to classify and grade lens opacities systematically by imaging.

16. A nuclear cataract consists of a central opacification or coloration in the nucleus of the lens. There are different types of nuclear cataracts, accompanied by either brunescence, opalescence, or both.

17. A cortical cataract can be located central or peripheral to the visual axis through the lens, and sometimes may best be appreciated by retroillumination or retinoscopy.

18. Posterior subcapsular cataracts occur on the posterior, or back portion of the capsule.

19. A type of opacity known as a water cleft or vacuole can also sometimes form in the lens of the eye due to some medical conditions, including changes in a patient's blood sugar level. A water cleft may be transient. Water clefts may have the appearance and may cause the same symptoms of normal cataracts, and they may appear and disappear as the patient's blood sugar level rises and falls.

20. Cataracts are usually bilateral, but do not always develop at the same rate in both eyes of a single patient.

21. All types of cataracts are capable of scattering light within the eye, and may prevent the light from focusing properly on the retina, thereby causing more profound visual disabilities in sub-ideal lighting situations such as problems with glare or seeing in dim light.

22. Certain types of cataracts present characteristics that may be associated with a higher risk for intraoperative and postoperative complications. One such characteristic is a dense cataract, which is described as an opalescent, brunescent, or black cataract. 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.

23. Cataracts may cause patients a variety of visual symptoms, including reduced Snellen visual acuity, reduced near vision, glare disability, reduced contrast sensitivity, altered color vision, and vertical diplopia, among others. A patient may experience one or more of these symptoms without experiencing the others.

24. Due to their light scattering effect, cataracts may cause patients to experience a significant reduction in their contrast sensitivity – the ability to distinguish between objects of varying shades and luminances before they experience a significant reduction in their Snellen vision – the ability to perceive dark black letters or numbers on a bright white background. As a result, cataracts may cause objects to appear "washed out" even though they are in focus and

therefore not blurry.

25. Reduced contrast sensitivity may occur for a number of reasons and may affect a patient's ability to see in dim light or bright light, or to distinguish objects of similar contrast under any lighting conditions.

26. Patients may complain of problems such as difficulty with glare and functioning in bright light, difficulty functioning in dim light, difficulty driving, difficulty driving at night, seeing starbursts around lights, and blurry distance, near, and intermediate vision, among other things. These complaints may be related to cataracts.

EVALUATION OF CATARACTS

27. Evaluation of a patient whose visual complaint may be related to a cataract involves (a) diagnosing a cataract, (b) confirming that the cataract is a significant factor related to the visual impairment and symptoms described by the patient, and (c) excluding or identifying other ocular or systemic conditions that might contribute to visual impairment or affect the surgical plan or ultimate outcome.

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

A. Determining And Recording Patient's History

29. To get the most comprehensive information concerning a patient's history, an ophthalmologist may use patient interviews and patient questionnaires.

30. It is appropriate for ophthalmologists to use cataract-specific patient questionnaires in order to help patients identify and report visual symptoms due to cataract, and an ophthalmologist is entitled to rely upon the symptoms reported on such questionnaires. Questionnaires used alone are not intended to be the basis for determining the need for cataract surgery and should not be used to set a threshold for such surgery.

31. It is important to obtain the patient's own assessment of his or her functional status and any difficulties the patient may be having with vision. It is also important to realize that patients adapt to their visual impairment and may fail to notice a functional decline because the development of cataract may be very insidious.

32. It is acceptable and professional for an ophthalmologist and his technicians to paraphrase their patients' complaints and to record their own understanding of the patients' symptoms as long as it is reasonably and accurately based on everything revealed during the course of the examination by the patient, his or her vision testing, and the eye doctor's physical exam.

33. It is acceptable practice for an ophthalmologist to add his or her own conclusions regarding the patient's symptoms and to record those additions in the "history" section of the patient's chart during the course of an examination as long as they are reasonably and accurately

based on everything revealed during the course of the examination by the patient, her vision testing, and the eye doctor's physical exam.

34. It is also appropriate for an ophthalmologist to record his or her conclusions regarding patient symptoms in the "history" section of the chart, regardless of when during the examination those symptoms were revealed and whether or not the patient acknowledges the symptoms revealed by vision testing as long as they are reasonably and accurately based on everything revealed during the course of the examination by the patient, her vision testing, and the eye doctor's physical exam.

35. An ophthalmologist must ensure the evaluation of the patient and the patient's medical chart accurately documents the symptoms, findings, and indications for treatment.

36. While questionnaires and the gathering of information by technicians are useful and acceptable, a combination of patient interviews, questionnaires, and eye examinations is the best measure of patients' visual function prior to cataract surgery. Ultimately, when this combination of information is obtained, the physician should thoroughly and adequately discuss the information and any treatment decisions based on the information with the patient.

37. 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.

B. Determining The Existence Of Cataracts

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

39. Because the undilated pupil is only about 3 millimeters in diameter, and the normal lens is 13 millimeters, an ophthalmologist cannot view most of the lens of the eye unless the patient's pupils are first dilated. Dilation also enhances the quality of the view of the lens seen through a slit lamp. As a result, it is sometimes necessary to dilate a patient's eyes before performing a complete cataract evaluation, or ruling out the presence of cataracts.

40. However, many cataracts, in particular water clefts and oil droplet cataracts, may not be easily discernable through the slit lamp because they are disturbances, rather than discolorations, in the lens. These types of cataracts may best be appreciated by bouncing light off the back of the eye, a process called retroillumination. Retroillumination is normally performed with an instrument called a direct opthalmascope; it cannot be properly performed with a slit lamp.

C. Vision Testing and Cataracts

41. Because patients may not always recognize or report their visual symptoms, the impact of cataract on visual function should also be assessed through vision testing.

42. There is no single test that adequately describes the effect of a cataract on a patient's visual status or functional ability. Similarly, no single test defines the threshold for performing cataract surgery.

1. Snellen Testing

43. It is standard practice as part of a comprehensive eye examination to test visual function for a physician to determine a patient's best-corrected vision. Visual acuity testing, often called Snellen vision testing, measures a patient's ability to discern objects in a high contrast, ideal lighting environment, i.e., to see black letters or numbers on a white background with sources of glare eliminated by dimming ambient lighting and with the chart well illuminated.

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

45. In order to obtain a patient's best corrected Snellen visual acuity (BCVA), an ophthalmologist or his staff must refract a patient while the patient views the Snellen chart. Refraction is the process of changing the patient's corrective lenses until the patient's ability to view the Snellen chart is optimized. A patient may be refracted in a dilated or undilated state, or both.

46. In a patient with a normal eye, as long as a patient is re-refracted after dilation, he or she should normally achieve the same best corrected Snellen visual acuity score both before and after dilation.

47. If a patient achieves a better or worse Snellen score after dilation, that fact may be indicative of ocular pathology warranting further investigation by the eye doctor; as a result, post-dilation refraction may be a helpful diagnostic tool.

48. A patient's Snellen vision score may be affected by many factors independent of refractive error or eye disease, including but not limited to the amount of ambient light in the examination lane, the type of chart used, and how hard the ophthalmologist or technician "pushes" the patient to see the letters on the chart; as a result of these and other factors, a patient may achieve different Snellen scores in different physicians' examination lanes.

49. Supplemental preoperative ophthalmic tests are not specific for testing for cataracts but may help to characterize a patient's symptoms.

2. Contrast Sensitivity Testing

50. Contrast sensitivity testing (CST) measures the eye's ability to detect subtle variation in shading by using figures that vary in contrast, luminance, and spatial frequency. It is a more comprehensive measure of visual function than visual acuity, which determines perception of high-contrast letters and numbers. In the patient who complains of visual loss and has lens changes, contrast sensitivity testing may demonstrate a significant loss of visual function not appreciated in testing of visual acuity.

51. Decreased contrast sensitivity may occur for a number of reasons, and CST is therefore not a specific indicator of visual loss due to cataracts.

52. Decreased contrast sensitivity may cause patients to have difficulty seeing in low-contrast situations such as driving at night, discerning where the grey pavement ends and the grey shoulder begins, or distinguishing the edges of stair treads.

53. CST results, in some cases, may correlate more closely with patients' self-described cataract symptoms than do Snellen visual acuity scores.

54. CST, in some cases, may be a better measure than Snellen acuity of visual disability caused by cataracts, and by early cataracts in particular because it may identify cataract induced vision loss earlier than Snellen testing.

55. In some cases, early lens opacity diminishes contrast sensitivity and patient-reported quality of life before it affects Snellen visual acuity.

56. There are several valid methods of testing patients' contrast sensitivity. The FDA has endorsed the contrast sensitivity test method used in Dr. Chase's office, a sine wave-based test manufactured and designed by VectorVision, for cataract evaluation. However, in spite of substantial progress over the past few years, CST devices and methods continue to lack standardization. For example, neither the FAA nor the U.S. Air Force require CST for pilots.

3. Glare Testing

57. Glare testing determines the degree of a patient's visual impairment caused by the presence of a light source located in the patient's visual field. Cataracts may cause severe visual disability in brightly lit situations such as ambient daylight or from oncoming auto headlights at night. Visual acuity in some patients with cataract is normal or near normal when tested in a dark examination room, but when these patients are retested using a source of glare, visual acuity or contrast sensitivity may drop precipitously.

58. The most common standardized method to simulate glare in an office setting is the Brightness Acuity Tester (BAT) manufactured by Mentor; the BAT provides a highly standardized way of simulating glare. Dr. Chase used the BAT.

59. The BAT can simulate three bright light conditions: (1) High – direct overhead sunlight; (2) Medium – partly cloudy day; (3) Low – bright overhead commercial lighting. BAT should be performed at all three settings in order to determine the functional visual acuity in various bright light conditions.

4. Combining Contrast and Glare Testing

60. CST and BAT are sometimes legitimate parts of a cataract evaluation and may reveal significant real-life, cataract-related visual deficits that are not detected by Snellen testing.

61. It is sometimes medically appropriate to perform glare testing, and to use the BAT, after a patient's eyes are dilated. The BAT product manual specifically contemplates that an ophthalmologist may re-perform BAT testing after dilation to determine if functional vision improves or worsens with dilation. Reasons to do so include simulating real life conditions such as when persons are subjected to glare during night driving when their pupils are dilated.

62. In the absence of an ocular abnormality, such as a visually significant cataract, dilation will not materially affect the CST/BAT scores of most patients subjected to BAT. A patient with a visually significant cataract may experience a rise or fall in her CST/BAT score after dilation, depending on the type and location of the cataract. A physician may thus gain valuable diagnostic information by re-performing CST and BAT after dilation.

63. The tests results of the complaining patients who were retested using CST and BAT after dilation confirm that retesting patients after dilation will not necessarily decrease their tests scores.

64. Of all of the ophthalmologists who testified, Dr. Chase was the only one who used CST in evaluating the 11 complaining patients. CST weighed heavily in Dr. Chase's decision-making process regarding cataract surgery; he basically considered it to be the gold standard for when to offer a patient cataract surgery. Since this case began, Dr. Patrick Morhun, has begun using CST in evaluating his cataract patients because, it provides him with an extra piece of information, but it is not a huge part of his decision-making process regarding cataract surgery.

PERFORMING CATARACT SURGERY

65. Cataract surgery is almost always an elective procedure: the patient must decide whether her visual defects justify undergoing the procedure.

66. Cataract surgery is appropriate when the patient's visual function no longer meets the patient's needs and cataract surgery offers a reasonably likelihood of improvement.

67. If cataracts are a significant factor causing difficulty with any task important to the patient – whether it is recreational, occupational, or otherwise – that difficulty is sufficient to justify cataract surgery if the patient desires.

68. Cataract surgery should not be performed where the patient does not desire surgery, where glasses or visual aids provide vision that meets the patient's needs, where surgery will not improve visual function, and where the patient's quality of life is not compromised by his or her vision.

69. Patients' attitudes and reactions to being diagnosed with cataracts and/or offered surgery vary widely. Some accept it matter-of-factly and some are greatly disturbed by such news.

70. The physician can determine whether a cataract impairs vision, but only the patient can decide when her visual symptoms interfere with something she wants to do to a degree such that she is willing to undergo cataract surgery to remedy them.

71. A patient cannot decide whether her symptoms are sufficiently bad to justify surgery until the physician offers cataract surgery to her and explains all of the potential risks and benefits involved.

72. Thus, consistent with the standard of care, it is appropriate for a physician to provide a patient with the choice of cataract surgery when: (1) the patient has cataracts; (2) the patient complains of symptoms that the doctor attributes to the cataracts; (3) glasses are unlikely to resolve the symptoms; and (4) cataract surgery offers a reasonable likelihood of improving the

patient's vision.

73. Along with providing a patient with the choice of cataract surgery, 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.

74. The fact that a patient decides that his or her lifestyle is not sufficiently compromised by his or her vision, and therefore chooses not to have cataract surgery, does not by itself render the physician's offer or recommendation of surgery inappropriate.

75. A cataract patient's pre-operative visual acuity is a poor predictor of postoperative functional improvement; therefore the decision to recommend cataract surgery should not be made on the basis of visual acuity alone. No single test defines the threshold for performing cataract surgery.

76. In some cases, a physician cannot tell how a cataract will affect a patient's vision simply by the appearance of the cataract. In some cases, a cataract does not need to reach a certain appearance, grade, or level of maturity, before surgery may be indicated.

77. Even early cataracts may cause patients to experience significant visual symptoms, and those symptoms can sometimes justify surgery.

78. Depending on the individual circumstances of any case, it may be acceptable for ophthalmologists to perform cataract surgery on patients with Snellen scores of 20/20 or 20/25.

79. Good, competent doctors can reasonably disagree as to when the AAO PPP standard has been met as to a particular patient.

RESPONDENT'S EXAMINATION OF PATIENTS

80. Patient history information was collected in Respondent's office by having patients fill out an Eye Health History form, on which the patient was asked to self-report his or her medical history and visual symptoms.

81. Beginning in approximately 2002, each patient that had been previously diagnosed with cataracts was also asked to fill out a Lifestyle Questionnaire, on which he or she was asked to self-report any visual symptoms. The Lifestyle Questionnaire used by Dr. Chase is based on a published, peer reviewed questionnaire, and is an effective tool to identify and document cataract-induced visual defects.

82. Both the Eye Health History form and the Lifestyle Questionnaire were filled out by the patients before they saw Dr. Chase. Some patients had difficulty completing some of the questions, because they could not be answered with a clear or black-and-white response.

83. Dr. Chase's technicians then interviewed the patients regarding their visual symptoms, noting any reported symptoms in the chart and placing quotations around exact quotes from patients.

84. After interviewing the patient, the technician normally measured the patient's vision using an autorefractor; this measurement served as a starting point for the technician's manual refraction of the patient using a Snellen chart.

85. The technician then gave the patient a pair of trial frames with their best refraction in order to provide the correct amount of panascopic tilt to the patient's spectacles while recording the patient's best corrected Snellen visual acuity. This refraction was performed prior to dilating the patient and the results were normally recorded on a sticky note or on the autorefractor slip which was placed on the front of the patient's chart.

86. Using the trial frames, the technician measured the patient's contrast sensitivity, utilizing the VectorVision CST and simulating glare by use of the Brightness Acuity Tester (BAT) set on high, which simulated ambient light on a sunny day with the sun overhead. The technician recorded the results of this test on the VectorVision CST slips, indicating that the results were obtained using simulated glare, and placed those slips prominently inside the front cover of the patient's chart.

87. Dr. Chase's technicians performed all of the CST and BAT testing; Dr. Chase did not perform it himself, and did not know how to administer it. The technicians always tested the patient's CST with BAT vision utilizing the trial frames with lenses that provided the patient with his or her best corrected visual acuity. The technician always tested the patient's CST with BAT vision prior to dilation.

88. The methods of testing contrast sensitivity and glare utilized by Dr. Chase's technicians, and relied upon by Dr. Chase, conform to the FDA's standards for contrast sensitivity and glare testing, and may measure and provide a means of evaluating functional vision loss not appreciated in testing of visual acuity.

89. Dr. Chase sometimes questioned his patients regarding their symptoms, using their patient questionnaires, the technician's history and their CST with BAT and Snellen test results to guide his questioning. With certain patients, the evidence established that Dr. Chase did not thoroughly and adequately discuss with those patients the information acquired about the condition of the patients' eyes. He did not adequately discuss with them the questionnaires, the information acquired by the technicians, or the results of the examinations of the patients' eyes. He did not discuss with them whether their vision was meeting their needs and the extent to which their vision may be compromising their quality of life.

90. Dr. Chase performed a full physical examination of each patient's dilated eyes using his slit lamp to look at the inside of the patient's eye through the dilated pupil. He also examined most patients' lenses through retroillumination, utilizing his direct ophthalmoscope.

91. According to Respondent's testimony, each patient was refracted at least twice by the technician, and then Dr. Chase re-refracted every patient a third time to determine their best corrected visual acuity after dilation using the Snellen chart.

92. On some occasions, Dr. Chase diagnosed patients with cataracts but did not offer them surgery because they were not complaining, or because the symptoms voiced by the patients were not sufficiently severe, even if the patient's CST/BAT results were well below normal.

93. On other occasions, Dr. Chase diagnosed patients with cataracts, but their CST/BAT scores indicated that their visual function was not badly compromised, and he did not offer them surgery.

94. For each of the eleven complaining patients, Dr. Chase measured the patient's Snellen vision and recorded it in the chart, usually on the test slip that also contained the patients' CST and CST with BAT results.

95. The vision test slip containing each patient's Snellen and CST/BAT results was affixed prominently within the inside cover of each patient's chart, along with any visual acuity scores obtained through use of an autorefractor. As a result, all of the patient's vision test scores were somewhere in the chart.

96. In addition to recording all vision scores within the front cover of the patient's chart, Dr. Chase would place the vision score that he felt most accurately reflected the patient's real life functional vision (either Snellen or CST/BAT) next to the preprinted letter "V," on the first page of his examination notes for each particular patient visit.

97. According to Respondent's testimony, if a CST w/BAT score were placed by the "V," he would also place the patient's CST/BAT result immediately after the patient's refraction on the same page just beneath the "V," clearly labeling it "CST/BAT" to show that it was the result of the patient's best possible refraction.

98. There is no standardized way of recording patients' vision, particularly when a physician measures both his patients' Snellen and contrast sensitivity vision. Instead, most ophthalmologists have their own way of keeping their charts. Ophthalmologists should organize their charts, and their vision scores, in a way that allows them to provide their patients with the highest quality ophthalmic care.

99. When sending his medical records to another physician, Dr. Chase always included a summary chart clearly and correctly labeling his patients' vision scores as Snellen or CST/BAT.

100. While there is no evidence that any healthcare provider or insurer was ever confused, either in rendering treatment or paying a claim, by Dr. Chase's method of recording his patients' vision, there was evidence that CHP and Quality Improvement Department had raised concerns about cataract surgery performed by Respondent and his medical record documentation. Dr. Chase responded to those concerns.

101. There exists no requirement that ophthalmologists describe or rate the physical severity of their patients' cataracts; rather they should determine whether and to what extent the cataract interferes with the patient's functional vision. Those ophthalmologists that do rate their cataracts do not all use the same system.

102. Some physicians grade their patients' cataracts in order to help guide their surgical technique: more mature cataracts often take more time and carry more risk to remove than do earlier cataracts, while others grade cataracts in the belief it will help them assess how much the cataract is affecting the patient's vision.

103. Ophthalmologists may disagree on the grading of cataracts. Ophthalmologists may sometimes fail to see a cataract, particularly an early cataract. Sometimes one ophthalmologist will observe a cataract that another ophthalmologist will not.

104. Clinicians' identifications and physical descriptions of cataracts are to a certain degree subjective and may display wide inter-observer and intra-observer variations. That subjectivity applies not only to the grade and location/type assigned to a cataract; but may extend to whether a cataract exists or not.

105. Doctors may combine physical and functional components when describing their patients' cataracts, adjusting the grade or description they assign to a cataract in order to take account of how that cataract is affecting the patient's vision. They then record their description in the physical examination portion of the chart.

106. However, the Committee finds that a cataract described as dense is a cataract that presents characteristics that may be associated with a higher risk for intraoperative and postoperative complications. Those characteristics include appearing opalescent, brunescenct, 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.

107. Doctors normally do not rely on another doctor's description of a cataract to guide his or her surgical decision—in part because such descriptors are so subjective. Instead, they always examine and grade the patients' cataracts themselves, using their own systems.

108. In diagnosing and describing 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.

109. Dr. Chase's technicians would record his patients' symptoms in the "history" section of his examination notes. Often, his technicians would paraphrase and summarize the patients' complaints; occasionally they would place quotation marks around a complaint, indicating it was a verbatim quote.

110. When Dr. Chase examined his patients, reviewed their test results, and spoke to them about their vision, he would often record his own conclusions regarding the patients' symptoms in the history section of the chart, thereby summarizing all of the diagnostic information available to him.

111. Other ophthalmologists sometimes record their own conclusions regarding their patients' symptoms in the "history" section of their charts during the latter part of the patient exam.

112. The evidence established that with certain patients, Dr. Chase's conclusions recorded in their medical charts were inaccurate. Those inaccuracies occurred, because Dr. Chase did not engage in a thorough and meaningful discussion with those patients concerning all of the information that was acquired during the patients' examination.

113. Dr. Chase testified that he would give each patient a statement, which he has referred to

as a hypothetical second opinion. He testified that he would tell the patient "that if she went to any other medical eye doctor . . . and said she came for a second opinion because Dr. Chase said she needed cataract surgery, she would be told [that] if she saw well enough to suit her, its not going to damage her eyes not to have the surgery."

114. Recorded in patients' medical records was the phrase to the effect that the second opinion was given. Dr. Chase maintains that his scribes chose to record this. He further maintains that he did not instruct his scribes to use this shorthand description, but neither did he disapprove of this notation because as he reviewed his charts, it allowed him to determine whether he had provided his patients with his normal informed consent presentation.

115. There was evidence from certain patients that contradicted this. The Committee finds that Dr. Chase's version of his so-called second opinion statement is not credible. Dr. Chase's discussion of second opinions to his patients as established by the testimony of the patients was misleading, confusing, and improper.

116. Dr. Chase then directed the patient to a registered nurse, who he employed to provide a much more extensive informed consent presentation to the patients, and to schedule them for surgery if they chose this option after learning more about the procedure. The informed consent presentation and related documents are comprehensive. The informed consent process was intended to provide, and in some cases did provide patients with the information they needed to make an intelligent decision regarding surgery.

117. Respondent's patients were not required to sign the informed consent form on the day they scheduled the surgery. Instead, patients were normally asked to take the document home, review it, discuss it with family, and call with any follow-up questions. The patients were required to sign the informed consent document on the day of surgery, after all of their questions were addressed.

118. Surgical patients were also provided with educational cataract pamphlets pre-printed by the American Academy of Ophthalmology, the largest and most mainstream organization of ophthalmologists.

THE INDIVIDUAL PATIENTS

Helena Nicolay Nordstrom (Patient # 1)

119. Helena Nordstrom saw Dr.Chase as a patient on one occasion on January 17, 2003. She went to see Dr. Chase, because she was having eye strain when looking frequently at a computer screen. She also reported that she experienced blurred vision, headaches, and nausea that she attributed to her eyestrain.

120. Ms. Nordstrom believed she needed a new glasses prescription, as she had in the past. Her regular eye doctor, an optometrist, was too busy to see her at that time. Her boyfriend suggested she see Dr. Chase, and she was able to schedule an appointment with Dr. Chase. At that visit, Ms. Nordstrom was tested and examined by Dr. Chase and his staff.

121. The technician who took Ms. Nordstrom's history recorded that Ms. Nordstrom also reported darker vision in her left eye than in her right and an inability to see to drive clearly at

night. Ms. Nordstrom admitted that she may have reported symptoms to that effect.

122. When she viewed the Snellen chart in Dr. Chase's office after being refracted and with her best corrected vision, she performed poorly, both as measured by the autorefractor, the technician, and by Dr. Chase himself.

123. Ms. Nordstrom testified that when her Snellen vision was tested prior to dilation, the Snellen chart appeared blurry.

124. 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.

125. Dr. Chase diagnosed Ms. Nordstrom with cataracts; he performed his physical examination of Ms. Nordstrom's lenses through both a slit lamp and a direct ophthalmoscope, which provides retroillumination and enables the physician to better detect disturbances in the lens cortex, while her eyes were fully dilated.

126. Dr. Chase's technicians performed CST/BAT testing on Ms. Nordstrom prior to dilating her eyes. That testing as reported by the technicians showed that she was experiencing a significant contrast sensitivity deficit. Her contrast sensitivity, according to some measurements, was 40% below the bottom of the normal range for her age and 85% below the average.

127. Dr. Chase and his staff performed an extensive examination of Ms. Nordstrom, performing three refractions, automated visual fields, and even an Amsler grid test to rule out macular problems.

128. Dr. Chase determined that Ms. Nordstrom was suffering from cataracts, which were causing her vision problems.

129. Recorded in Dr. Chase's medical chart for Ms. Nordstrom is the diagnosis of the lenses of her eyes as having "Dense cent nuc cort cataract os > od.", which is abbreviated language for dense central nuclear cortical cataracts with the cataract in the left eye being denser than the cataract in the right eye. Dr. Chase subsequently described her cataracts as being a "circular opacity in the central cortex and nucleus."

130. Nothing resembling a dense central nuclear cortical cataract was seen or diagnosed during any of Ms. Nordstrom's prior or subsequent eye examinations by other eye care professionals.

131. Dr. Chase recommended that Ms. Nordstrom receive cataract surgery if she wanted to remedy her symptoms. Respondent further stated to Ms. Nordstrom that she not get a second opinion, that he was the only one in Vermont who could do the procedure, and he pointed to a plaque on the wall as he stated that he had all the credentials to do the surgery. Respondent referred Ms. Nordstrom to his counseling nurse to receive preoperative teaching and the informed consent regarding cataract surgery.

132. Dr. Chase ordered Ms. Nordstrom to get a 2-hour blood sugar and CBC test, but did not explain to her the reason for it. Ms. Nordstrom understood that she was to get the blood test prior to undergoing surgery and that she was coming back for more pre-operative testing. She

never clearly understood that the scheduled surgery was contingent upon the results.

133. A possible reason that 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. It is reasonable for a doctor who fears that a patient's cataracts may be transitory to order the necessary blood tests and hold a spot on the surgical schedule pending the outcome of the blood tests.

134. Fluctuating blood sugar levels and/or diabetes can cause transitory cataracts.

135. Water clefts may look like normal cataracts upon physical examination and may cause the same symptoms as normal cataracts, including blurry vision and reduced contrast sensitivity. Water clefts would not be described as dense central nuclear cortical cataracts.

136. 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.

137. 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.

138. Recorded in Dr. Chase's medical chart for Ms. Nordstrom was the notation that the patient had been given a second opinion. There was conflicting evidence as to what this "second opinion" statement was. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion statements to this patient, and to his patients in general, is not credible. The Committee further finds that Dr. Chase suggested to Ms. Nordstrom that she not get a second opinion, and he bolstered this suggestion by telling Ms. Nordstrom that he was credentialed to perform this surgery and was the only physician in Vermont who could do this type of surgery. Dr. Chase's statements to Ms Nordstrom regarding second opinions were misleading, confusing, and improper.

139. Respondent did not engage in a thorough discussion with Ms. Nordstrom regarding the information acquired about the condition of her eyes. He did not adequately discuss with her the questionnaires, the information acquired by the technicians, or the results of the extensive examination of her eyes. He did not discuss with her whether her vision was meeting her needs and the extent to which her vision may be compromising her quality of life.

140. Ms. Nordstrom, as instructed by Respondent, went to see the staff nurse, scheduled an informed consent meeting for the following week, and reserved a spot on the surgical schedule one week after that.

141. Ms. Nordstrom was very upset with the diagnosis of cataracts by Dr. Chase. She

believed she was too young to have cataracts, and she felt saw fine. She scheduled an appointment for an eye examination with her optometrist, Dr. Eriksson. After having the examination, she decided not to go through with the surgery with Dr. Chase, and she declined to get the blood sugar test Dr. Chase had ordered.

142. Because Ms. Nordstrom believed that she had been recommended cataract surgery that she did not need, she filed a complaint with the Board. Subsequently, the Board arranged for her to be examined by New Hampshire ophthalmologist Dr. Patrick Morhun.

143. The Board's investigator, Phil Ciotti, scheduled Ms. Nordstrom to be examined by Dr. Morhun on June 30, 2003. Mr. Ciotti instructed her not to tell Dr. Morhun about her complaint filed with the Medical Board.

144. At the outset of his examination, Dr. Morhun asked Ms. Nordstrom if she was experiencing any visual symptoms, or whether she had experienced any visual symptoms in the past. Dr. Morhun testified that, in order for him to make an accurate diagnosis of a patient, it is important for him to know if that patient experienced any past visual symptoms. When asked by Dr. Morhun, Ms. Nordstrom stated that she had no particular complaints.

145. If Ms. Nordstrom had been experiencing past symptoms, that fact would have been important to Dr. Morhun's assessment of her vision. Dr. Morhun agreed that if Ms. Nordstrom had been experiencing blurry vision, dim vision, and has having trouble reading, that may have changed his opinion, except for his opinion that he saw no cataracts.

146. Dr. Morhun did not examine Ms. Nordstrom's lens (or any of his patients' lenses) using retroillumination from a direct ophthalmoscope; rather, he used only his slit lamp to examine her lens. Dr. Morhun did not perform glare testing or contrast sensitivity testing on Ms. Nordstrom.

147. Dr. Morhun saw no cataract when he examined Ms. Nordstrom in June 2003, and her lenses appeared normal. He found nothing consistent with a diagnosis of dense nuclear cortical cataracts.

148. At this time, Ms. Nordstrom's visual acuity from Snellen testing was recorded as 20/15 and 20/15. Dr. Morhun's examination confirmed, however, that her vision did not improve due to new glasses because her prescription was virtually unchanged as compared either to the glasses she wore into Dr. Chase's office or Dr. Chase's refraction. As a result of his examination, Dr. Morhun could not find any reason for Ms. Nordstrom's radically improved vision.

149. When a patient's blurry vision has resolved, but there has been no change in her glasses prescription, fluctuating blood sugar may be a potential cause of the patient's problems. Dr. Morhun did not order a blood sugar test for Ms. Nordstrom. Dr. Morhun had no reason to order a blood sugar test for Ms. Nordstrom. Ms. Nordstrom is not diabetic.

150. Dr. Morhun, when reviewing Dr. Chase's charts for the Board's investigator, overlooked that Dr. Chase had refracted Ms. Nordstrom, overlooked that her glasses had not changed, and overlooked that he had been faxed incomplete records that were obviously missing the bottom one-quarter of each page due to Investigator Ciotti's faxing error, whether intentional or not.

151. Respondent has detailed through cross-examination several shortcomings regarding Dr. Morhun's review of Ms. Nordstrom's records, his examination of her eyes, and his subsequent opinions. The Committee recognizes these; however, Dr. Morhun remained consistent and unwavering that he saw no cataract when he examined Ms. Nordstrom in June 2003, that her lenses appeared normal, and that he found nothing consistent with a diagnosis of dense nuclear cortical cataracts. The Committee finds this conclusion credible and consistent with the evidence. At the time of Dr. Morhun's examination, Ms. Nordstrom did not have dense central nuclear cortical cataracts as diagnosed and described by Respondent after Respondent examined her on January 17, 2003.

152. Ms. Nordstrom demonstrated significant anger toward Dr. Chase during her hearing testimony, at one point shouting at Dr. Chase about his purported inability to treat her mother's dry eye condition and asking him if he remembered her.

153. Ms. Nordstrom, as all of the witnesses in this matter, previously testified under oath at court hearings and depositions. She was extensively cross-examined during her testimony at this hearing. Inconsistencies appear when comparing all of her testimony related to this matter. None of the inconsistencies establish that she is an unreliable witness as maintained by Respondent. The Committee finds that she is a credible witness, who is able to accurately recollect and testify about her interactions with Respondent.

Judith Salatino (Patient #2)

154. By 2003, Dr. Chase had treated Judith Salatino, her children and her husband for over 35 years. He had always provided good care to Ms. Salatino and her family, and Ms. Salatino had an extremely high degree of loyalty to and trust in Dr. Chase.

155. Dr. Chase first diagnosed Ms. Salatino with bilateral cataracts during a January 26, 1994 examination when she was 54 years old. He informed Ms. Salatino that because those cataracts were not interfering with her vision, the proper response was simply to monitor them to ensure any effect on her vision that did develop would be detected.

156. Ms. Salatino had another examination by Dr. Chase on August 10, 1995, at which it was noted on her chart that she complained that lights were bothering her more when driving at night. Dr. Chase again noted the presence of bilateral cataracts and again decided to address them only through continued monitoring.

157. Dr. Chase examined Ms. Salatino again on September 28, 1998, and during that visit it was noted on Ms. Salatino's chart that she was having more difficulty reading signs and license plates and that it was harder for her to see at night due to glare. No surgery was discussed and, instead, Dr. Chase continued to monitor her cataracts.

158. On June 8, 2000, Ms. Salatino circled on an Eye Health History form that she was bothered by glare. At her June 14, 2000 examination visit, Dr. Chase's technician noted that Ms. Salatino was experiencing blurriness in both eyes on her chart. In addition to noting the presence of bilateral cataracts that he described as dense central nuclear cortical cataracts, Dr. Chase identified Ms. Salatino as a glaucoma suspect and took photographs of her optic nerve to assist him in detecting any onset of glaucoma.

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

160. Mrs. Salatino went to see Dr. Chase on June 11, 2003, because she thought she needed a new prescription for her glasses. It had been three years since she had seen him, and her eyes would get tired after reading for a long time.

161. At her June 11, 2003 examination, Ms. Salatino circled on her Eye Health History form that she was bothered by glare and floaters. On a Lifestyle Questionnaire that she completed and signed she checked off that her vision sometimes made it a problem for her to read items with small print, see traffic signs, and see steps. She also said that she was sometimes bothered by poor night vision, seeing rings around lights, glare, hazy or blurry vision and seeing in poor or dim lighting.

162. While she indicated that she was bothered by poor night vision or by glare while driving, she was not bothered to the point where she couldn't drive. At the time she was driving both in the day and at night and was doing all the things she liked to do.

163. Ms. Salatino's contrast sensitivity with glare test revealed that she tested significantly below average according to some measurements. On the same CST test slip, located on the inside left jacket cover, was noted her Snellen test score of 20/30 and 20/25. The 20/100 contrast sensitivity test result is also set forth twice on the first page of the June 11, 2003 exam sheet adjacent to each other, and the second notation of the score is labeled "CST w/BAT, no significant improvement with glasses." Her contrast sensitivity, according to some measurements, was 69% below the bottom of the normal range for her age.

164. After the examination, Dr. Chase concluded that Ms. Salatino was unable to see clearly to drive in glare at night and he noted that on her medical record. He also noted that she had dense central nuclear cortical cataracts in both eyes.

165. On June 11, 2003, over nine years after Dr. Chase had first diagnosed Ms. Salatino with cataracts, he offered cataract surgery.

166. Dr. Chase spoke to Ms. Salatino for approximately 10 to 15 minutes explaining the risks and benefits of cataract surgery. He told her she did not need new glasses but instead needed cataract surgery. She was shocked by this statement.

167. Dr. Chase showed Ms. Salatino the CST test slip, showed her a point on the slip, and told her that the test result was so bad that if she was a truck driver, she could no longer drive.

168. Respondent did not engage in a thorough discussion with Ms. Salatino regarding the information acquired about the condition of her eyes. He did not adequately discuss with her the questionnaires, the information acquired by the technicians, or the results of the extensive examination of her eyes. He did not discuss with her whether her vision was meeting her needs and the extent to which her vision may be compromising her quality of life.

169. Ms. Salatino thought it was a serious matter and was "scared", and she asked Dr. Chase about getting a second opinion. He told her that he was an expert in this field, and that he was giving her a second opinion that she needed to have this surgery.

170. Recorded in Dr. Chase's medical chart for Ms. Salatino was the notation that the patient had been given a second opinion. There was conflicting evidence as to what this "second opinion" statement consisted of. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion statements to this patient, and his patients in general, is not credible. Dr. Chase's statements to Ms. Salatino regarding a second opinion suggested that a second opinion was not really necessary and were confusing, misleading, and improper. Ms. Salatino did not seek a second opinion from another physician prior to surgery.

171. Ms. Salatino, wanting to see if she could delay the operation until she was covered by Medicare, asked Dr. Chase if the surgery could be delayed. He stated that it should be done right away, and she should not wait to have it done.

172. Dr. Chase had performed successful cataract surgery on Ms. Salatino's husband in 2001 that had a very positive effect on his life. Ms. Salatino had participated in her husband's informed consent procedure and thus had pre-existing familiarity with the nature, risks and benefits of cataract surgery.

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

174. 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.

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

176. During the five weeks between June 11 and July 15, 2003, Ms. Salatino considered the issue of whether her vision was meeting her needs and after thinking about it, consulting with her husband and reading the written material she had received, she decided to have the cataract surgery on July 15, 2003.

177. On July 15 she signed the informed consent form in Dr. Chase's office and had cataract surgery performed on her right eye. A few days later she completed a patient survey form, in which she stated that the surgery was painless and made easy by virtue of having it performed in the doctor's office and by the consideration of the people in Dr. Chase's office. She agreed to speak to other patients about her favorable experience with cataract surgery.

178. Dr. Chase examined Ms. Salatino the day after the surgery on July 16, and he and Ms. Salatino agreed that she would undergo cataract surgery on her left eye on July 22. However, that surgery did not occur because the Medical Practice Board suspended Dr. Chase' s medical license on July 21, 2003.

179. Phil Ciotti contacted Ms. Salatino and told her she should have her eyes examined by another doctor that he recommended. Ms. Salatino did not believe that this could be true about Dr. Chase, and she thought it was nonsense. She did not go to the doctor recommended by Mr. Ciotti. She took her friend's recommendation and made an appointment to see Dr. Irwin.

180. Dr. Irwin examined Ms. Salatino on July 25, 2003. Ms. Salatino informed Dr. Irwin's technician, who recorded it in her medical record, that she had been doing well and had no problems with the operated eye. Ms. Salatino said that she had been having trouble with night driving and distance vision in general. She also complained to Dr. Irwin's technician that her unoperated left eye had a brown haze and that she noticed it now especially since having the surgery performed on her right eye. In Dr. Irwin's writing, there appears a notation that both eyes are blurry, eyes tired.

181. Ms. Salatino confirmed that she had told Dr. Irwin's technician that she had been having trouble with her night driving and distance vision in general, and explained that was why she had the surgery, because driving was important to her. She said that after the surgery, everything she viewed through her operated right eye was clear and whiter and that objects appeared discolored, beige, cream, browner or sepia out of her left eye. She also explained that the gray circles on Dr. Chase's CST test chart had looked brown to her before she had the surgery.

182. Dr. Irwin diagnosed her with a bare trace cortical opacity in her left eye and no capsular opacities in the right eye. He noted that it was not a clinical cataract. He found nothing that would indicate a dense central nuclear cortical cataract. He found she had 20/20 best corrected Snellen vision in her left eye, which is excellent vision. He performed a slit lamp exam and a BAT test. He did not perform contrast sensitivity testing. He did not recommend surgery.

183. Dr. Irwin told Ms. Salatino that he did not see anything in her left eye that needed surgery, and that made her extremely upset and angry toward Dr. Chase. Three days later, on July 28, 2003, she filed a lawsuit against Dr. Chase accusing him of fraud, malpractice, assault and battery, and intentional infliction of emotional distress.

184. Dr. Irwin wrote a memorandum for the Medical Practice Board on July 25, 2003, in which he stated that Ms. Salatino had seen Dr. Chase because her eyes were somewhat blurry and were tired at times. Ms. Salatino denied symptoms of glare. She knew what a refraction was, but did not recall Dr. Chase performing one. Dr. Irwin concluded his memo indicating that Ms. Salatino had a bare trace of lens opacity in her left eye, which he did not consider to be a clinical cataract.

185. Respondent has established inconsistencies and omissions in the records and testimony of Dr. Irwin. None of these materially affect Dr. Irwin's opinion that he saw no cataract in Ms. Salatino's left eye that could be accurately described as a dense central nuclear cortical cataract.

186. Ms. Salatino was examined by the State's expert ophthalmologist witness, Dr. Patrick

Morhun, on September 5, 2003. She told Dr. Morhun that before the surgery she had not been having trouble with driving at night. That denial was directly contradicted by the medical records of both Dr. Chase and Dr. Irwin, which reflected that Ms. Salatino had complained that her vision was causing her difficulty driving at night. 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".

187. Dr. Morhun, unlike Dr. Irwin, observed a 1+ nuclear cataract in Ms. Salatino's left eye. Unlike Dr. Irwin, Dr. Morhun did not observe a cortical cataract in Ms. Salatino's left eye. Dr. Morhun concluded that surgery on the cataract was not indicated.

188. The testimony of these two witnesses consistently establishes that at the time of their respective examinations, Ms. Salatino did not have a dense central nuclear cortical cataract in her left eye as diagnosed and described by Respondent.

189. Judith Salatino previously testified regarding this matter under oath at court hearings and depositions. She was extensively cross-examined during her testimony at this hearing. Her inability to accurately remember a few items was outweighed by her consistent ability to recall and testify about the details of her examinations by Dr. Chase. The Committee finds that she is a credible witness.

Susan Lang (Patient # 4)

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

191. Ms. Lang is part of a class action suit against Dr. Chase, in which she is seeking money damages from him.

192. Susan Lang was first examined by Dr. Chase in 1977; she was a patient for over 25 years by the time Dr. Chase performed cataract surgery on her right eye on July 15, 2003. Dr. Chase first diagnosed Ms. Lang with cataracts in 1990.

193. Dr. Chase diagnosed Ms. Lang with cataracts in 1991, 1992, 1993, 1995, 1998, and 1999, and described them in her medical records as cataracts. He did not offer or recommend cataract surgery to her on any of these occasions, because she was not complaining of symptoms attributable to her cataracts.

194. In 2000, Ms. Lang complained of decreased vision in low illumination. Ms. Lang also first complained of experiencing glare and halos when she was driving at night in the rain or snow. As a result, she felt that her vision was not as good as it had been, or as it should be. (Ms. Lang's visual symptoms were bothering her, and she had become uncomfortable driving at night some evenings, but it did not prevent her from driving.

195. Dr. Chase did not ask Ms. Lang how the problem with glare affected her life in terms of her work or travel, and they did not talk about those circumstances.

196. Ms. Lang's CST/BAT vision, as tested by Dr. Chase's technician in 2000, was well below normal for her age, according to some measurements, measuring patch 1 on the 6 c/d column of the test. This score was a significant drop from her 1999 CST/BAT score, which measured patch 5 and patch 3 in her left and right eyes respectively.

197. Dr. Chase concluded that her symptoms and CST/BAT deficit were caused by her cataracts, and identified no other cause for her symptoms or poor test scores. Recorded in Dr. Chase's medical chart for Ms. Lang is the diagnosis of the lenses of her eyes in 2000 as having dense central nuclear cortical and pp cataracts in both eyes.

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

199. Ms. Lang asked if there were any alternatives to surgery, and Dr. Chase suggested that she could try an anti-reflective coating on her glasses. Ms. Lang tried the anti-reflective coating, and it worked very well, but it did not completely eliminate the symptoms she was experiencing.

200. Although Dr. Chase offered Ms. Lang cataract surgery in 2000, he did not engage in a thorough discussion with Ms. Lang regarding the information acquired about the condition of her eyes. He did not adequately discuss with her the questionnaires, the information acquired by the technicians, or the results of the examination and tests of her eyes. He did not discuss with her whether her vision was meeting her needs and the extent to which her vision may be compromising her quality of life.

201. Ms. Lang declined surgery in favor of anti-glare treatment on her glasses, she was satisfied with the care she received in 2000 and returned for an examination by Dr. Chase in 2002.

202. Ms. Lang returned for an eye examination in 2002 mainly to check whether her Plaquenil medication was causing any difficulty with her vision. She filled out an Eye Health History form, on which she indicated that she was currently being bothered by glare and halos. She had problems with halos and glare, but she did not have trouble with her vision if she was wearing her glasses.

203. After Ms. Lang's eye examination and testing, Dr. Chase, in an agitated state, said to her that he could not understand why she was not having complaints about how the cataracts were affecting her vision. Dr. Chase showed Ms. Lang the results of her CST/BAT, told her repeatedly that she had failed the cataract test, but otherwise did not explain the results of the test. He further told her he could not recommend cataract surgery to her unless she had complaints associated with her cataracts. Respondent's demeanor made Ms. Lang feel uncomfortable.

204. Respondent did not engage in a thorough discussion with Ms. Lang regarding the information acquired about the condition of her eyes. He did not adequately discuss with her the questionnaires, the information acquired by the technicians, or the results of the examination and tests of her eyes. He did not discuss with her whether her vision was meeting her needs and the extent to which her vision may be compromising her quality of life.

205. Ms. Lang was shocked and upset, because she did not have trouble with her vision if she was wearing her glasses. In response, Ms. Lang did not voice any complaints, and Dr. Chase did not offer her cataract surgery. He did not attempt to pressure her into voicing a complaint, and he did not suggest that she articulate complaints that were not true.

206. Recorded in Dr. Chase's medical chart for Ms. Lang is the diagnosis of the lenses of her eyes in 2002 as having dense central nuclear cortical and pp cataracts in both eyes.

207. Ms. Lang returned to Dr. Chase for an examination in 2003. 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."

208. She also complained to Dr. Chase that she was having trouble focusing on a small scientific instrument at her work. It was important that Ms. Lang be able to see this instrument well, because it was susceptible to breakage. Ms. Lang further informed Dr. Chase that she was bothered by the bright lights that she used at work in order to see the small parts of scientific instruments.

209. Recorded on Ms. Lang's medical chart was the notation that she can't see to drive safely at night due to glare from cataracts. Ms. Lang never told Respondent this, because her vision was not affecting her ability to drive. This notation represented Respondent's own conclusion regarding this patient's symptoms.

210. Dr. Chase's technicians performed two CST/BATs on Ms. Lang during the course of her June 30, 2003 examination. One of the tests was performed prior to dilation, one was performed after dilation, and both test scores were recorded in Ms. Lang's chart. Both test scores, according to some measurements, showed that Ms. Lang's contrast sensitivity and glare vision was 73% below the very bottom of the normal range for her age and 85% to 90% below the average. Dr. Chase measured Ms. Lang's best corrected Snellen vision as 20/40 in both eyes.

211. Recorded in Dr. Chase's medical chart for Ms. Lang is the diagnosis of the lenses of her eyes in 2003 as having dense central nuclear cortical and pp cataracts in both eyes. Dr. Chase concluded that Ms. Lang's cataracts were responsible for her symptoms and her below-normal CST/BAT scores and that cataract surgery would improve her vision; his examination revealed no other cause for her vision problems.

212. Because she was having a problem focusing on the instrument at work, Ms. Lang asked Respondent if that was a sign of the cataracts. Respondent indicated that it could be due to them and that surgery could correct the problem.

213. Respondent did not engage in a thorough discussion with Ms. Lang regarding the information acquired about the condition of her eyes. He did not adequately discuss with her the questionnaires, the information acquired by the technicians, or the results of the examination and tests of her eyes. He did not offer glasses as an alternative. He did not discuss with her whether her vision was meeting her needs and the extent to which her vision may be compromising her quality of life.

214. Ms. Lang did ask Respondent whether she should get a second opinion. Respondent, in a loud voice, responded that she should not, picked up a plaque and said that he was the only

ophthalmologist in Vermont that was a member of a particular society. Ms. Lang, as a result, did not seek a second opinion.

215. Recorded in Ms. Lang's medical chart was the notation that the patient was given cataract pamphlets and a second opinion. There was conflicting evidence as to what this second opinion notation was. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion statements to this patient, and to his patients in general, is not credible. The Committee further finds that Dr. Chase suggested to Ms. Lang that she not get a second opinion, and he bolstered this suggestion by referring to his particular society membership. Dr. Chase's statements to Ms. Lang regarding a second opinion suggested that a second opinion was not really necessary and were confusing, misleading, and improper.

216. Ms. Lang made an appointment to come back on July 3, 2004 to participate in the informed consent process with Dr. Chase's nurse.

217. The nurse discussed the informed consent packet with Ms. Lang in detail, asked her to take it home and read it and to call if she had any questions. After completing the informed consent process, Ms. Lang understood that cataract surgery was elective. No one placed any pressure on Ms. Lang to have cataract surgery.

218. Ms. Lang chose to go forward with cataract surgery on her right eye on July 15, 2003. After the surgery, the glare that Ms. Lang experienced in her right eye was eliminated. She still experiences difficulty seeing small objects out of her left, unoperated eye.

219. After cataract surgery on her right eye was complete, Ms. Lang was planning on having cataract surgery on her left eye. On a patient survey, she indicated that she was very satisfied with the care she had received, that Dr. Chase's staff was very professional and kind, and she agreed to speak positively to other potential surgical candidates about her experience.

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

221. Ms. Lang did not report any visual symptoms to him, including not having any problems with glare. Dr. Tabin did not perform glare testing or contrast sensitivity testing on Ms. Lang.

222. Dr. Tabin informed Ms. Lang that she had received well-performed surgery on her right eye, with a good visual result, and offered no opinion on whether that surgery had been necessary or unnecessary.

223. After examining Ms. Lang's left eye, Dr. Tabin found what he termed a trace cortical cataract, and described it as a little whitening of the layer around the nuclear region. The cataract formation that Dr. Tabin found in Ms. Lang's left eye was not consistent with Respondent's diagnosis of a dense central nuclear pp cataract. The cataract Dr. Tabin found would have a relatively small effect on her vision in her left eye.

224. The testimony of Dr. Tabin establishes that at the time of Dr. Tabin's examination of Ms. Lang's left eye, she did not have a dense central nuclear cortical and pp cataract in her left eye as diagnosed and described by Respondent.

225. Based on his examination and the information he had, Dr. Tabin determined that Ms. Lang was able to function extremely well with her visual function, and he did not recommend cataract surgery to Ms. Lang.

226. Dr. Tabin's successor, Dr. Pecsenyicki, diagnosed Ms. Lang with a 1+ cortical cataract in her left eye on subsequent visits.

227. Ms. Lang testified that today she has very good vision in the right eye on which Dr. Chase performed cataract surgery, and in the left eye on which there has been no surgery.

228. On August 18, 2003, Ms. Lang filed a complaint with the Board. Ms. Lang previously testified regarding her physician-patient relationship with Respondent under oath at court hearings and depositions. She was extensively cross-examined during her testimony at this hearing. A few inconsistencies appear when comparing all of her testimony related to this matter. The few inconsistencies are outweighed by her consistent ability to recall and testify about the details of her examinations by Respondent. None of the inconsistencies establish that she is an unreliable witness as implied by Respondent. The Committee finds that she is a credible witness, who is able to accurately recollect and testify about her interactions with Respondent.

Marylen Grigas (Patient # 5)

229. Marilyn Grigas began seeing Dr. Chase for ophthalmological care in 1981. She appreciated his direct and business like manner of communicating and thought he was very professional.

230. Ms. Grigas had enjoyed excellent vision during most of her life.

231. She was first diagnosed with bilateral cataracts by Dr. Chase during an examination in 1997 when she was 55 years old. She had no visual complaints and Dr. Chase informed her the cataracts were not interfering with her vision and required no action other than monitoring. Dr. Chase advised Ms. Grigas' primary care physician of her cataract diagnosis.

232. Ms. Grigas was examined by Dr. Chase again in 1998 and no action was taken with respect to her cataracts as they were not affecting her vision.

233. Dr. Chase examined Ms. Grigas' eyes in 1999 and found that both her contrast sensitivity test and Snellen test scores were above normal. She was able to see patch 5 and 7 on the CST with glare test. He continued to monitor her cataracts.

234. Dr. Chase examined Ms. Grigas' eyes again in 2000. His diagnosis of bilateral cataracts remained the same from 1997 through 2000, it was recorded on Ms. Grigas' medical chart as cataracts.

235. It was determined by Dr. Chase during Ms. Grigas' 2001 examination that her cataracts had affected her Snellen vision and that her spectacle prescription needed to be changed to address her symptoms. Dr. Chase provided new spectacles to Ms. Grigas with the new prescription, and informed Ms. Grigas' primary care physician of the change. Ms. Grigas'

contrast sensitivity with glare test scores continued to be in the normal range with Ms. Grigas seeing patch 5 in both eyes.

236. Recorded on Ms. Grigas' medical records for her 2001 eye examination was the diagnosis of dense central nuclear cortical cataracts in both eyes.
237. During the five years and five eye examinations Marilyn Grigas had between 1997 and 2001, she expressed no significant functional vision complaint related to her cataracts, her contrast sensitivity with glare test scores were normal or above, and Dr. Chase did not discuss cataract surgery with Ms. Grigas and instead simply monitored her cataracts and addressed change in her vision by prescribing new glasses.

238. Dr. Chase examined Ms. Grigas' eyes again on September 9, 2002, when she was 59 years old. She completed an Eye & Health History questionnaire on which she did not note that she currently was experiencing any eye symptoms. The chief complaint for that visit was that she was there for a glaucoma check.

239. Ms. Grigas' CST results during the 2002 examination indicated a decline from her 2001 examination, falling from patch 5 in both eyes to patch 2 and 3, respectively, in her left and right eyes. Ms. Grigas' contrast sensitivity, according to some measurements, was 60% below the bottom of the normal range for her age and 85% below the average.

240. At some point after Ms. Grigas' eye examination and tests, it was recorded on her medical chart that she can't see to drive at night in glare due to cataracts. This notation represented Respondent's own conclusion regarding this patient's symptoms. Marilyn Grigas never told anyone that she couldn't see to drive safely at night. She had no visual problems that were affecting her ability to do the things she wanted to do.

241. Recorded on Ms. Grigas' medical records for her 2002 eye examination is the diagnosis of the lenses of her eyes as having dense central nuclear cortical cataracts in both eyes.

242. Respondent and Ms. Grigas' had a discussion about her declining test results and some difficulties with her vision, such as decreased vision in dim light, threading a needle in dim light, some unpleasantness driving at night, and darker vision. Since Respondent had been telling Ms. Grigas for several years that she had cataracts, she wondered whether her difficulties were because of the cataracts.

243. Respondent believed that the cataracts were the cause of her difficulties and suggested that surgery and removal of the cataracts would help. Ms. Grigas' was taken aback, because the discussion seemed to quickly lead to scheduling. Ms. Grigas thought she would get some pamphlets, think about it, and then have the cataracts removed later that year. Dr. Chase said that he had an opening on his surgical schedule the next day.

244. Dr. Chase gave Ms. Grigas a very quick summary of the risks and benefits of the surgery and told Ms. Grigas that she should meet with the nurse who would give her additional information. She thought she would have the surgery, but she was concerned with the quickness with which she thought it was being scheduled. Respondent did not engage in a thorough discussion with Ms. Grigas regarding the information acquired about the condition of her eyes. He did not adequately discuss with her the questionnaires, the information acquired by the technicians, or the results of the examination and tests of her eyes. He did not offer glasses as an

alternative. He did not discuss with her whether her vision was meeting her needs and the extent to which her vision may be compromising her quality of life.

245. Recorded in Ms. Grigas' medical chart was the notation that the patient was given a second opinion. There was conflicting evidence as to what this second opinion notation was. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion to his patients in general is not credible. The Committee further finds that the notation that the patient was given a second opinion was misleading and improper.

246. At some point after her meeting with Dr. Chase, Ms. Grigas completed and signed a form stating that she had decided to have cataract surgery because: 1) she was bothered by glare; 2) she had trouble seeing in poor or dim light and driving at night; and 3) she was concerned about driving.

247. Ms. Grigas met with the nurse, Susan Grohn, and found her to be very professional and helpful and she viewed Ms. Grohn as a patient advocate. Ms. Grigas recalls asking Grohn if she could attend a play rehearsal the next day and Grohn said most people prefer to sleep. She told the nurse that she did not want to have the surgery the next day, and Ms. Grohn told her not do anything that she wasn't comfortable with. Grohn then informed Dr. Chase that Ms. Grigas did not want to have the surgery the next day. In response, Dr. Chase came back into the room and authoritatively said that there would not be a problem. Ms. Grigas was upset by the entire series of events.

248. The evidence as to the date on which the cataract surgery on Ms. Grigas' left eye was scheduled is conflicting, but the totality of the records indicates that the surgery on her left eye was scheduled for 6:30 a.m. on October 1, 2002, and that Ms. Grigas was instructed to begin her pre-operative drops on September 28, 2002.

249. Dr. Chase's medical record indicated that Nurse Grohn had notified Ms. Grigas' primary care physician of Ms. Grigas' October 1st left eye surgery. Another entry on September 17th, indicated that Ms. Grigas had called and cancelled the cataract surgery, saying she might schedule at a later date.

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

251. About a year after her 2002 examination, Ms. Grigas decided to write a complaint to the Medical Practice Board. Thereafter, Ms. Grigas had her eyes examined by Dr. Cavin on September 12, 2003. Dr. Cavin's records reflect that Ms. Grigas informed his office that her vision was good, driving at night was not a problem, and she was not bothered by glare.

252. Dr. Cavin examined her lenses and described them to have peripheral cortical cataract changes or mild peripheral cortical spoke-type changes, and that the nucleus is quite clear. He found the cataracts to be clinically relatively insignificant. His findings were not consistent with a dense central nuclear cortical cataract in both eyes. A dense cataract is quite remarkably

different from a clinically insignificant cataract. It can be whitish or brunescent. At the time of Dr. Cavin's examination, Ms. Grigas did not have dense central nuclear cortical cataracts as diagnosed and described by Respondent after Respondent examined her eyes in 2002.

253. Dr. Cavin further concluded that while she had the cataract formation that he described, Ms. Grigas was getting along well with her vision and cataract surgery was not medically necessary.

254. Dr. Cavin examined Ms. Grigas' eyes again on September 17, 2004. He described her lenses on that examination to have a trace peripheral cortical spoke in the right eye and a 1 plus cortical spoke in the left eye, with a nuclear sclerosis trace in both eyes. She was happy with her current vision, and he determined that cataract surgery was not medically necessary.

255. Dr. Cavin examined Ms. Grigas' eyes again on September 29, 2005. He described her lenses substantially the same as he did in the previous visit. The patient was happy with her vision, and he did not recommend cataract surgery at that time.

256. Ms. Grigas previously testified regarding her physician-patient relationship with Respondent under oath at a previous trial. She was extensively cross-examined during her testimony at this hearing. A few inconsistencies appear when comparing all of her testimony related to this matter. The few inconsistencies are outweighed by her consistent ability to recall and testify about the details of her examinations by Respondent. None of the inconsistencies establish that she is an unreliable witness as implied by Respondent. The Committee finds that she is a credible witness, who was able to accurately recollect and testify about her interactions with Respondent.

Donald Olson (Patient # 7)

257. Donald Olson, a retired dental educator, testified on October 2, 2006. He was examined by Dr. Chase on a single occasion on September 9, 1995 when he was 63 years old.

258. Dr. Olson first filed a complaint with the Medical Practice Board eight years later after reading and hearing publicity regarding the suspension of Dr. Chase's license in July 2003.

259. Dr. Olson had numerous symptoms of visual impairment when he was examined by Dr. Chased in September, 1995. He complained to Dr. Chase's technician that his near vision had decreased, he was bothered by glare and he tried to avoid driving at night because of his vision. He informed Dr. Chase that he retired in 1993, because he noticed his vision was decreasing and he was concerned he might miss something, especially on x-rays. He also testified that he had difficulty reading his cello music in the dim light of the orchestra pit and may have discussed that with Dr. Chase.

260. Dr. Olson thought he was seeing fairly well when he visited Dr. Chase, but actually he had failed to appreciate that his Snellen vision with his existing glasses had declined significantly to 20/40 and 20/50. By changing his prescription, Dr. Chase was able to improve his Snellen vision to 20/25 in both eyes. However, his contrast sensitivity with BAT, achieved with his very best corrected vision, was no better than 20/100. His contrast sensitivity, according to some measurements, was 73% below the bottom of the normal range for his age and 85% to 90% below the average.

261. Dr. Chase diagnosed Dr. Olson with cataracts in both eyes, with the opacification being more advanced in his right eye than his left eye. Respondent did not describe the cataracts as dense.

262. The only specific comment Dr. Olson remembers Dr. Chase making about his vision is that if he were a long haul truck driver, his vision would preclude him from working. He has no specific recollection of Dr. Chase telling him that if he wanted to correct his vision he needed surgery. (Olson at 121.) Dr. Chase did not advise him about the risks or benefits of surgery and definitely did not pressure him to have surgery.

263. Dr. Chase's medical records for Dr. Olson, unlike the records of each of the other 10 patients comprised by the State's charges, do not mention any discussion regarding cataract surgery.

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

265. Dr. Guilfoy's records do not indicate that he ever performed a dilated slit lamp exam on Dr. Olson. Dr. Guilfoy testified that he probably never did a dilated slip lamp exam on Dr. Olson. Dr. Guilfoy explained that he uses a general Snellen threshold of 20/40 and an absolute Snellen threshold of 20/30 before he will offer cataract surgery to a patient, unless there is an unusual situation. If a patient can be refracted to a best corrected vision better than 20/40 Snellen, Dr. Guilfoy generally dispenses with a dilated slip lamp exam unless something else is going on.

266. Dr. Olson testified that Dr. Guilfoy informed him that his cataracts were not significant enough to warrant surgery, which as Dr. Guilfoy explained, means his best corrected Snellen vision was no worse than 20/40. Dr. Guilfoy does not conduct glare or contrast sensitivity testing in his practice.

267. Dr. Guilfoy examined Dr. Olson on March 25, 2000 and described his cataracts as being moderately severe in both eyes. He did not test his incoming Snellen vision, but was able to correct his Snellen vision to 20/25-2 and 20/25-1, noting a continued myopic shift in his right eye.

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

269. In January 29, 2004, Dr. Olson thought he was seeing well when he went to see Dr. Guilfoy for an examination, but his Snellen vision with existing glasses was 20/40-1 and 20/40 – 2. The best that Dr. Guilfoy could correct his Snellen vision to was 20/30 and 20/25-2. Dr. Olson apparently did not recognize his poor incoming vision, as Dr. Guilfoy's records indicate

that the patient did not note any difficulties. Dr. Guilfoy's records describe the lenses of Dr. Olson's eyes as abnormal with moderate severe nuclear sclerosis in both eyes.

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

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

272. During the entire period between Dr. Olson's initial visit to Dr. Guilfoy in 1998 and his cataract surgery in 2006, Dr. Olson had not reduced either his day or night driving.

273. Mr. Olson previously testified regarding his physician-patient relationship with Respondent under oath at deposition. He was extensively cross-examined during his testimony at this hearing. He demonstrated a consistent ability to recall and testify about the details of his examination by Respondent. The Committee finds that he is a credible witness, who was able to accurately recollect and testify about his interactions with Respondent.

Jane Corning (Patient # 8)

274. Jane Corning testified on October 3, 2006. She was first examined by Dr. Chase on August 1, 1996 when she was 53 years old. She wanted to have an eye examination, because she was having a little difficulty seeing with her near vision. Dr. Chase did not diagnose her with cataracts. With a prescription change, she was able to see above average on the Snellen chart, testing at 20/15 in both eyes.

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

276. After seeing a different ophthalmologist, Ms. Corning scheduled another appointment for an eye examination by Dr. Chase on June 30, 2000. During that visit Ms. Corning, under the section "Are you currently experiencing any eye symptoms?" on her Eye Health History, circled "floaters" and "bothered by glare," but she did not consider it to be a problem for her. Dr. Chase's technician recorded that Ms. Corning was bothered by glare when driving on wet roads at night.

277. Ms. Corning's best corrected Snellen vision test score was 20/20 in her right eye and 20/25 in her left eye. This represented a one line drop in the right eye and a two line drop in the left eye from the Snellen test results she had achieved four years earlier in 1996.

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

279. Dr. Chase diagnosed Ms. Corning as having cataracts in both eyes. Recorded on Ms. Corning's medical records for her 2000 eye examination was the diagnosis of dense central nuclear cortical cataracts in both eyes.

280. After evaluating Ms. Corning's objective test scores, her visual complaints and his observations of her lenses during the dilated slit lamp examination, Dr. Chase concluded that Ms. Corning was not seeing clearly in glare because it was interfering with her vision, and he noted his conclusion on his medical record.

281. Dr. Chase informed Ms. Corning that she had cataracts in both eyes that they were visually significant, and that cataract surgery would be appropriate to correct their effect on Ms. Corning's vision. Dr. Chase did not, to Ms. Corning's recollection, tell Ms. Corning that she "needed" to have the surgery. Dr. Freeman testified that it was reasonable for Dr. Chase to offer Ms. Corning cataract surgery.

282. She was "shocked," worried and upset to learn she had cataracts, although Dr. Chase never raised his voice or spoke in a threatening way to her.

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

284. Ms. Corning's recollection is that Dr. Chase suggested that she could be scheduled for surgery the following Tuesday which, given that the exam day was Friday, June 30th, meant July 4th, although Ms. Corning was not then aware that the following Tuesday was July 4. Dr. Chase's office was closed on July 4th and no surgery was scheduled for that day. Ms. Corning conceded that she might have been mistaken in thinking Dr. Chase meant Tuesday, July 4th rather than July 11th or 18th.

285. Jane Corning felt very rushed, upset, and confused for three reasons: (1) she was shocked and upset to learn she had cataracts; (2) she thought she was being scheduled for surgery four days later on July 4th, which was too soon for her to evaluate the decision; and (3) Dr. Chase's hands were shaking. She did not understand why she needed surgery, because she felt she had no symptoms.

286. Recorded in Ms. Corning's medical records was the notation that the patient was given a second opinion. There was conflicting evidence as to what this second opinion notation was. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion to his patients in general is not credible. The Committee further finds that the notation that the patient was given a second opinion was erroneous and improper.

287. Also recorded in Ms. Corning's medical records was the notation that she can't see clearly in glare, interfering with vision, and wants cataracts removed. Respondent never asked Ms. Corning whether she wanted cataracts removed, and she never told Respondent she wanted cataracts removed. This notation represented Respondent's own erroneous conclusion regarding this patient. Ms. Corning testified that the notation that she wanted cataracts removed was a false statement.

288. Dr. Chase told Ms. Corning to see the nurse, and Ms. Corning went to do so without communicating to him that she had decided in her own mind not to have the surgery. Dr. Chase concluded that she wanted to have the surgery and he noted that on the first page of her medical record.

289. Respondent did not engage in a thorough discussion with Ms. Corning regarding the information acquired about the condition of her eyes. He did not adequately discuss with her the questionnaires, the information acquired by the technicians, or the results of the extensive examination of her eyes. He did not discuss with her whether her vision was meeting her needs and the extent to which her vision may be compromising her quality of life.

290. Corroborating the lack of discussion between Respondent and Ms. Corning concerning any of these matters is the notation that she wanted cataracts removed. Although not a deliberate falsification, the notation was a misunderstanding or an erroneous assumption that resulted in an inaccuracy. Had Respondent engaged in a thorough and meaningful discussion with his patient, Respondent would not have left the examination with the misunderstanding of Ms. Corning's intention and wouldn't have entered his erroneous assumption.

291. The purpose for Ms. Corning to see the nurse was for the nurse to explain the nature, risks and benefits of the surgery and give her written information to take home and consider. When the nurse offered her printed material to take and read, Ms. Corning refused it.

292. Dr. Chase's records reflect that Ms. Corning was never scheduled for surgery, because she told the nurse that she wanted to discuss the issue with her husband and research it on the internet before deciding, and that she would call back in the fall. The complete medical record indicates that on June 30, 2000, Ms. Corning decided to defer the decision regarding cataract surgery.

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

294. On October 5, 2000, Jane Corning saw Dr. Irwin for a second opinion regarding cataract surgery. She complained on that visit that she had difficulty driving at night with wet roads and seeing close objects but that reading was not too bad. Ms. Corning recalls that Dr. Irwin informed her that she did not have cataracts and that if she was to have a problem from cataracts, it would not develop until 20 years down the road.

295. Dr. Irwin's medical records for his examination of Ms. Corning reflect her complaints regarding glare and close vision, that he diagnosed her with trace cortical cataracts in both eyes.

He did not find anything in the lenses of her eyes that would indicate a dense nuclear cortical cataract. He found her lenses to be very nearly clear. The testimony of Dr. Irwin establishes that at the time of Dr. Irwin's examination of Ms. Corning's eyes, she did not have dense central nuclear cortical cataracts in both eyes as diagnosed and described by Respondent.

296. Dr. Irwin found that her best corrected Snellen score was 20/20, 20/25, and that her Snellen scores the BAT on medium were 20/30, 20/40.

297. Dr. Irwin found nothing in his examination of Ms. Corning's eyes other than her cataracts that explain the slight drop in the Snellen scores when subjected to the BAT.

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

299. Dr. Irwin did not recommend cataract surgery for Ms. Corning, because her lenses were very nearly clear, with no dense central nuclear cortical cataracts; she had good vision by measurement; and her difficulty driving on a wet road was not enough of a problem.

300. Dr. Irwin wrote a letter to Ms. Corning's primary care physician on October 19, 2000. In pertinent part, he wrote that she was in for a second opinion, because she had been recommended to have cataract surgery on an urgent basis; that "she has a bit of difficulty driving on rainy nights (don't we all!)."; that her "vision dropped slightly to 20/30 and 20/40 respectively when subjected to glare conditions"; and that "there is just barely enough lens opacity to call it a cataract." He further wrote that the mere presence of a bit of lens haziness did not, in his mind, warrant the diagnosis of cataract and that her near vision problem could not be completely addressed with spectacles because her bifocals needed to be set at 14-16 inches for reading and were virtually useless to her when performing tasks at 5-6 inches (e.g., threading a needle). He concluded the letter stating that she was nearly asymptomatic from her lens opacity and he saw no reason for performing cataract extraction.

301. On June 4, 2004, Jane Corning was examined by Dr. Tabin. She complained she was bothered by glare, floaters and flashes of light. He diagnosed her as having bilateral nuclear cataracts that he rated, using his rating system, as trace. A trace opacity, as explained by Dr. Tabin, is a very small, usually a whitening of the nuclear material that doesn't have much effect on a light beam going through the lens. At the time of Dr. Tabin's examination of Ms. Corning's eyes, she did not have dense central nuclear cortical cataracts in both eyes as previously diagnosed and described by Respondent.

302. Ms. Corning previously testified regarding her physician-patient relationship with Respondent under oath at deposition. She was extensively cross-examined during her testimony at this hearing. A few inconsistencies appear when comparing all of her testimony related to this matter. The few inconsistencies are outweighed by her consistent ability to recall and testify about the details of her examinations by Respondent. None of the inconsistencies establish that she is an unreliable witness as implied by Respondent. The Committee finds that she is a credible witness, who was able to accurately recollect and testify about her interactions with Respondent.

Franklin Cole (Patient # 10)

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

304. Primary open angle glaucoma (glaucoma) is a progressive, chronic optic neuropathy in adults where intraocular pressure (IOP) and other currently unknown factors contribute to damage which, in the absence of other identifiable causes, there is a characteristic acquired atrophy of the optic nerve and loss of retinal ganglion cells and their axions.

305. If left untreated, glaucoma leads to progressive and irreversible blindness, beginning with visual field loss at the periphery and/or in the center of the visual field. As a result, early intervention is particularly important in treating glaucoma. Doctors should always err on the side of treatment.

306. A comprehensive glaucoma evaluation should include, among other things, measurement of IOP, a magnified stereoscopic evaluation of the optic nerve through a dilated pupil, imaging of the optic nerve through stereoscopic photographs or computer-based means, automated visual fields, and periodic gonioscopy (e.g., 1 to 5 years). The single most important indicator of glaucoma is the appearance of the optic nerve, which can only be assessed through a dilated pupil.

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

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

309. Dr. Chase continued to monitor Mr. Cole for glaucoma. On every visit he performed automated visual fields testing. On every visit he performed a dilated examination of the back of Mr. Cole's eye, including the optic nerve head. On every visit, he compared the appearance of Mr. Cole's optic nerve to the baseline photos he had taken in 1982. On every visit, he measured Mr. Cole's pressures. He also performed gonioscopy in 1988, examining the trabecular meshwork of Mr. Cole's eyes.

310. In 1988, Dr. Chase noted increased cupping in Mr. Cole's optic nerve head. He took a second set of stereoscopic optic nerve photos. Dr. Chase also performed gonioscopy on that same date and discovered pigment lodged in his trabecular meshwork, indicating that Mr. Cole was also suffering from pigmentary glaucoma. On that date, Dr. Chase diagnosed Mr. Cole with glaucoma and began treating him with eye drops.

311. In 1990, Dr. Chase again noted increased cupping in Mr. Cole's optic nerve head,

indicating, in Dr. Chase's opinion, that his glaucoma was progressing. Dr. Chase continued to treat Mr. Cole's suspected glaucoma with drops, rather than surgery.

312. In July 1992, Dr. Chase's automated visual fields testing showed that Mr. Cole had a constriction of his visual field, and that he had likely suffered permanent loss of peripheral vision from his glaucoma. Despite Dr. Chase's treatment of Mr. Cole's glaucoma through eye drops, Dr. Chase suspected the glaucoma was progressing.

313. On July 15, 1992, Dr. Chase also diagnosed Mr. Cole as having nuclear, cortical and posterior subcapsular cataracts. Recorded in Mr. Cole's medical records was the notation referring to the diagnosis as central nuclear cortical posterior subcapsular cortical cataracts in both eyes.

314. On that same date, Dr. Chase's technician recorded that Frank Cole reported that he was bothered by lights and was fearful when driving at night. Mr. Cole did not have a problem driving at night. While high beams bothered him, and he worried about animals jumping off from the side of the road, he was clear that he never had trouble with lights. If he told the technician that, it was because he was confused.

315. Mr. Cole's CST/BAT score of patch two in both eyes would indicate a significant contrast sensitivity deficit. According to some measurements, his contrast sensitivity was 60% below the bottom of the normal range for his age, and 85% to 90% below the average. Mr. Cole's Snellen test results were recorded as 20/15 in both eyes.

316. When Dr. Chase told Mr. Cole he had cataracts, Mr. Cole could not believe it. He had no trouble seeing and had no problems. His glasses were meeting his visual needs. He was able to do anything that he wanted. He had no problems working or driving.

317. Dr. Chase told Mr. Cole that if Mr. Cole went to get a second opinion, no other doctor would question Dr. Chase's diagnosis. Mr. Cole did not understand that statement, and he did not understand a lot of what transpired at that appointment with Dr. Chase. There was conflicting evidence as to what Dr. Chase discussed with this patient regarding a second opinion. Dr. Chase's explanation concerning his so-called second opinion statements to this patient, and his patients in general, is not credible. Dr. Chase's statements to Mr. Cole regarding second opinions suggested that a second opinion was not really necessary and were confusing and improper.

318. Respondent offered Mr. Cole combined glaucoma and cataract surgery. Dr. Chase then referred Mr. Cole to his nurse. However, Mr. Cole left Dr. Chase's office instead of seeing the nurse. Rather than seeing the nurse, Mr. Cole sought a second opinion from Dr. Cleary regarding the proposed cataract/glaucoma surgery.

319. Although Dr. Chase offered Mr. Cole surgery for cataracts, he did not engage in a thorough discussion with Mr. Cole regarding the information acquired about the condition of his eyes. He did not adequately discuss with him the information acquired by the technicians or the results of the examination and tests of his eyes. Respondent did not discuss with Mr. Cole whether his glasses provided vision that met his needs. He did not discuss with this patient whether his vision in general was meeting his needs and the extent to which his vision may be compromising his quality of life. Mr. Cole was confused, concerned, and did not understand much of what was discussed.

320. Dr. Cleary first examined Mr. Cole on February 25, 1993. She tested his visual acuity and recorded it as 20/20 and 20/20 minus 1. She did not refract him, because his vision was excellent. She measured the cup-to-disc ratio of his optic nerves—which can indicate how much optic nerve death has occurred due to glaucoma—to be .3 in the right eye and .35 in the left.

321. Dr. Cleary examined the lenses of Mr. Cole's eyes and found 1 plus cortical changes in both eyes. The changes were in the outermost portion of the lens. She considered the changes to be normal changes in the lenses of a 45-year-old person. She did not recommend surgery for the cortical changes she found.

322. During the February 25, 1993 examination, Dr. Cleary did not diagnose Mr. Cole with glaucoma. The field tests she performed on him were normal. She did not discontinue his glaucoma medication after that examination.

323. Dr. Cleary next saw Mr. Cole on September 7, 1993. Again, field tests for glaucoma indicated that the fields for Mr. Cole were normal. She asked Mr. Cole to discontinue his glaucoma medication a few days before his next examination, which was on March 8, 1994. There were no changes in the results of his tests at that examination, so his glaucoma medication was discontinued.

324. Over the next 13 years, Dr. Cleary continued to examine Mr. Cole regularly, the last visit being on October 23, 2006. She concluded that he never had glaucoma. She further concluded he did not have cataracts that required surgery.

325. At Dr. Cleary's request, Dr. Kathleen Maguire examined Mr. Cole for central serous retinopathy in 1995. Dr. Maguire's examination showed a visual acuity of 20/20 in each eye. Her examination further showed retinal pigment epithelial disruption with no evidence of persistent central serous fluid in the right eye, and no acute change in the left eye. Her examination of his lenses also indicated trace nuclear, cortical, and posterior subcapsular cataracts in both eyes, which she described as haze.

326. Neither Dr. Cleary's nor Dr. Maguire's diagnoses of Mr. Cole's lenses was consistent with Dr. Chase's diagnosis of his lenses.

327. Mr. Cole previously testified regarding this matter under oath at deposition. He was extensively cross-examined during his testimony at this hearing. Mr. Cole testified inaccurately concerning some events that occurred over the course of a twenty-five-year period. Overall, the inaccuracies in his testimony are outweighed by his ability to recall and testify about the details of several eye examinations. Furthermore, medical records and the testimony of other witnesses have corroborated relevant parts of Mr. Cole's testimony. The Committee finds that Mr. Cole is a credible witness.

Margaret McGowan (Patient # 11)

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

329. Ms. McGowan began receiving eye care from Dr. Chase in 1972. Dr. Chase first diagnosed Ms. McGowan with cataracts in 1997. She was surprised, because she felt her eyesight was fine. He diagnosed her with cataracts on each subsequent visit in 1999, 2001, and 2003.

330. In 1997, 2001 and 2003, recorded in Ms. McGowan's medical records is the diagnosis of the lenses of her eyes as dense central nuclear cortical cataracts in both eyes.

331. At the beginning of each of her office visits, Ms. McGowan would fill out the form questionnaires that were given to her by Dr. Chase's staff. On those forms she checked off or circled various symptoms. In 2003, on her Eye & Health History she checked off or circled that she was currently experiencing floaters and was bothered by glare. On her Lifestyle Questionnaire, she checked off that she sometimes had several symptoms including being bothered by poor night vision, glare, hazy or blurry vision, and seeing in poor or dim light. It was hard or her to answer them definitely, because it was not always "black and white".

332. Regarding Ms. McGowan's 1997 eye examination, Dr. Chase wrote in her medical records that she couldn't see to drive safely at night. Ms. McGowan did not make this statement to anyone. She drove often at night and did not have any trouble with such driving.

333. Regarding Ms. McGowan's 2001 eye examination, Dr. Chase wrote in her medical records that she couldn't see to drive safely at night, this interferes with her vision, and she wants cataracts removed. Ms. McGowan did not make this statement to anyone. She drove often at night and did not have any trouble with such driving. She did not want surgery, and she did not have surgery in 2001. She was upset when she saw this notation in her chart.

334. During several examinations, Dr. Chase told Ms. McGowan that she could get a second opinion, but he is the only certified doctor who could do the operation. Recorded in her medical records for her 2001 and 2003 examinations, were the notations that the patient was given second opinion. There was conflicting evidence as to what this second opinion statement and notations were. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion statements to this patient, and to his patients in general, is not credible. Dr. Chase's statements to Ms. McGowan regarding second opinions suggested that a second opinion was not really necessary and were confusing and improper.

335. Also recorded in Ms. McGowan's medical records for her 2003 examination was Respondent's notation that she couldn't see to drive safely in glare due to cataracts, wants cataracts removed.

336. Dr. Chase did not engage in a thorough discussion with Ms. McGowan regarding the information acquired about the condition of her eyes. He did not adequately discuss with her the questionnaires, the information acquired by the technicians, or the results of the tests. He did not discuss with her whether her vision was meeting her needs and the extent to which her vision may be compromising her quality of life. Ms. McGowan was never given the opportunity to explain her answers on the various questionnaire forms she completed.

337. In June 2003, Ms. McGowan's CST/BAT scores showed that she scored patch 1 and 2 on the 6 c/d row of the VectorVision test. Moreover, those CST/BAT scores had dropped since her

1999 and 2001 examinations. Her contrast sensitivity, according to some measurements, according to some measurements was 73% below the bottom of the normal range for her age and 85% to 90% below the average.

338. Ms. McGowan testified that in 2003 her CST with BAT was performed only after her eyes were dilated and that Dr. Chase himself performed the test. Her medical records indicate that one CST/BAT was administered by Amy Landry, and that it appears to have been administered prior to dilation.

339. After the 2003 examination, Ms. McGowan agreed to have cataract surgery, because she was scared that her vision was bad enough for her to go through surgery. She had cataract surgery on her right eye on July 1, 2003 and scheduled surgery on her left eye for July 22, 2003.

340. Dr. Chase's license was suspended before Ms. McGowan was able to have surgery on her second eye. As a result, Ms. McGowan received an examination from Dr. Tabin for follow up on her operated eye on August 5, 2003. Dr. Tabin informed Ms. McGowan that she had received well performed and successful cataract surgery on her right eye and diagnosed her as having a trace or 1 plus nuclear sclerotic cataract in her left, unoperated eye. Dr. Tabin offered her no opinion on whether her right eye surgery had been appropriate or not.

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

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

343. When Dr. Morhun asked Ms. McGowan if she was experiencing any visual problems she told him that she saw fine. She indicated to the effect that none of her daily living activities were affected, and she did not report any other symptom she reported to Dr. Chase and his staff.

344. Dr. Morhun measured Ms. McGowan's visual acuity and found it was 20/30 in the right eye and 20/20 in the left, unoperated eye. Dr. Morhun did not perform CST on Ms. McGowan.

345. Upon examining the lenses of Ms. McGowan's left eye, he found an early cataract that he described as posterior subcapsular. He indicated on a circle drawing in her medical record the location of the cloudiness or dusting in her left eye. Since she was 20/20 in her left eye, and the trace cataract was barely noticeable in his exam, he did not recommend surgery, but did recommend observation.

346. Dr. Morhun formed no opinion, and offered no opinion, on the medical appropriateness of the surgery performed on Ms. McGowan's right eye.

347. If Ms. McGowan had reported to Dr. Morhun the same symptoms that were noted in Dr. Chase's medical records for her, his recommendation regarding surgery "may well have been" different.

348. Ms. McGowan was examined by Dr. Irwin on June 21, 2005. He diagnosed her has having early trace cortical and nuclear cataracts in her left eye.

349. At the time of the examinations of Doctors Tabin, Morhun, and Irwin, Ms. McGowan did not have a dense central nuclear cortical cataract in her left eye. This evidence is not consistent with Dr. Chase's diagnosis and description of a dense central nuclear cortical cataract in Ms. McGowan's left eye after his examinations of her in 2001 and 2003.

350. Ms. McGowan has never had cataract surgery on her left eye.

351. Ms. McGowan previously testified regarding her physician-patient relationship with Respondent under oath at court hearings and depositions. She was extensively cross-examined during her testimony at this hearing. A few inconsistencies appear when comparing all of her testimony related to this matter. The few inconsistencies are outweighed by her consistent ability to recall and testify about the details of her examinations by Respondent. None of the inconsistencies establish that she is an unreliable witness as implied by Respondent. The Committee finds that she is a credible witness, who was able to accurately recollect and testify about her interactions with Respondent.

Joseph Touchette (Patient #12)

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

353. Mr. Touchette began seeing Dr. Chase for his eye care in 1978, when he received his first pair of glasses in order to remedy problems with his near vision.

354. Mr. Touchette was examined by Dr. Chase regularly from 1988 through 1998. On each of his six complete examinations, Mr. Touchette complained of increasing difficulty with near vision, including reading and working on the computer.

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

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

357. During his April 2, 1997 examination, Mr. Touchette again complained of decreased near vision. His last bifocal prescription had lasted him over two years. Dr. Chase first diagnosed Mr. Touchette with cataracts in both eyes on that date. Recorded in Mr. Touchette's medical records was the description of bilateral central nuclear cortical lens opacity. Dr. Chase did not propose cataract surgery to Mr. Touchette. He prescribed him another stronger reading

prescription for his bifocals, as he had done before.

358. At his June 16, 1998 examination, Mr. Touchette told Dr. Chase's technician that he was having difficulty reading the computer screen, trouble with intermediate and near vision, and that he had to work to see things clearly, and those problems were recorded in Mr. Touchette's medical chart.

359. On June 16, 1998, Dr. Chase and his technicians refracted Mr. Touchette in order to determine his best distance and near vision, as they had on every visit. The refraction demonstrated that a new reading prescription may not have provided him with any better vision, since there was very little if any change in his prescription.

360. Mr. Touchette's CST/BAT vision, when measured with his best possible glasses prescription prior to dilation, according to some measurements, was 60% below the bottom of the normal range for his age and 85% to 90% below the average.

361. Dr. Chase again diagnosed Mr. Touchette has having cataracts in both eyes. Recorded in Mr. Touchette's medical records for the 1998 examination was the description dense central nuclear cortical cataracts, right eye greater than left eye.

362. After the examination, Dr. Chase told Mr. Touchette that he had cataracts and needed surgery, and could be scheduled for Tuesday. Mr. Touchette was surprised and felt that things were going too fast. There was no discussion of options, of severity, or of recovery period. When Mr. Touchette tried to discuss the situation, Respondent stated that he, Respondent, was the only person who was qualified in the state to do the surgery, because he was the only one who had invested the time and the energy to get certified. Respondent further stated that it was of no use getting another opinion, because he was the best qualified in the state.

363. Recorded in Mr. Touchette medical records was the notation that the patient had been given a second opinion. There was conflicting evidence as to what this "second opinion" statement was. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion statements to this patient, and to his patients in general, is not credible. The Committee further finds that Dr. Chase suggested to Mr. Touchette that a second opinion was of no use, and he bolstered this suggestion by telling Mr. Touchette that he was the only credentialed physician in Vermont to perform this surgery and as a result was the best qualified physician in Vermont. Dr. Chase's statements to Mr. Touchette regarding a second opinion were confusing, misleading, and improper.

364. Also recorded in Mr. Touchette's medical records were the notations that cataract surgery alternatives and complications explained to patient and all cataract pamphlets given. Surgery alternatives and complications were never explained to Mr. Touchette and he was never given any cataract pamphlets. He considers those notations to be false.

365. Also recorded in Mr. Touchette's medical records was Respondent's notation that Mr. Touchette was not seeing clearly due to cataracts, interferes with life, wants cataracts removed. Mr. Touchette never told Respondent or anyone in Respondent's office that he wanted cataracts removed.

366. The appointment ended with Respondent suggesting that Mr. Touchette step over to the

scheduling nurse. Respondent then walked out of the examination room. Mr. Touchette did not tell Dr. Chase that he did not want cataract surgery, and he did not tell Dr. Chase that he was not going to see the nurse. After leaving Dr. Chase's examination lane, Mr. Touchette went directly to the office, paid his bill, and left the office without telling Dr. Chase of his intention not to schedule surgery. Mr. Touchette understood that it was his choice to proceed with cataract surgery or not.

367. Respondent did not engage in a thorough discussion with Mr. Touchette regarding the information acquired about the condition of his eyes. He did not adequately discuss with him any of the information acquired from Mr. Touchette or the results of the examination and tests of his eyes. Respondent did not discuss with him the potential risks and benefits to surgery, or any alternatives to surgery. Respondent did not discuss with Mr. Touchette whether his vision was meeting his needs and the extent to which his vision may be compromising his quality of life.

368. Corroborating the lack of discussion between Respondent and Mr. Touchette concerning any of these matters is the notation in Mr. Touchette's chart that he wanted cataracts removed. Although not a deliberate falsification, the notation was a misunderstanding or an erroneous assumption that resulted in an inaccuracy. Had Respondent engaged in a meaningful discussion with his patient, Respondent would not have left the visit with the misunderstanding of Mr. Touchette's intention and wouldn't have entered the misunderstanding in the chart.

369. Further corroborating the lack of discussion between Respondent and Mr. Touchette is Respondent's notation in Mr. Touchette's chart that Mr. Touchette's blurry vision interfered with his life. Although not a deliberate falsification, it was an erroneous assumption or an overstatement made as a result of the lack of a meaningful discussion with his patient.

370. Further corroborating the lack of discussion between Respondent and Mr. Touchette were the notations that cataract surgery alternatives and complications explained to patient and all cataract pamphlets given. Although these notations were not deliberate falsifications, they were erroneous assumptions that were entered as a result of the lack of a collaborative process.

371. Mr. Touchette went to see Dr. James Watson three months later to get a second opinion on cataracts, because surgery had been recommended. Dr. Watson examined Mr. Touchette on September 28, 1998. Mr. Touchette told Dr. Watson that he was having trouble seeing at an intermediate distance and reading his computer screen.

372. Dr. Watson performed a refraction on Mr. Touchette and his vision was correctible to 20/20 in each eye with a small change in his prescription. Dr. Watson did not perform CST or glare testing on Mr. Touchette.

373. Dr. Watson diagnosed Mr. Touchette as having trace nuclear sclerosis in both eyes. What Dr. Watson found was not consistent with a dense central nuclear cortical cataract. He had a minimal amount, what Dr. Watson considered not a true cataract or something that was bad enough to warrant surgery. This evidence is not consistent with Dr. Chase's diagnosis and description of a dense central nuclear cortical cataract in Mr. Touchette's eyes after Respondent's examination of Mr. Touchette in 1998. Mr. Touchette did not have a problem that cataract surgery would solve. For these reasons, it was Dr. Watson's opinion that surgery was not indicated.

374. Mr. Touchette has never had cataract surgery and does not desire to have such surgery. His glasses are providing him with satisfactory functional vision. His quality of life is not at all compromised by not having had cataract surgery.

375. Mr. Touchette previously testified regarding his physician-patient relationship with Respondent under oath at deposition. He was extensively cross-examined during his testimony at this hearing. He demonstrated a consistent ability to recall and testify about the details of his examinations by Respondent. The Committee finds that he is a credible witness, who was able to accurately recollect and testify about his interactions with Respondent.

William Augood Pierson (Patient # 13)

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

377. Mr. Augood was examined by Dr. Chase on one occasion on October 30, 2002. Mr. Augood met with a technician and filled out his own Eye & Health History form before he ever spoke with Dr. Chase. When the technician took his history, he told her that he was having some trouble with glare on bright days. When filling out his own Eye Health History form, Mr. Augood indicated that he was currently "bothered by glare." He explained when driving at night he saw points of light like a star. He also explained that he is bothered by glare on a very bright sunny day, but polarized sunglasses takes care of that.

378. Mr. Augood was first seen by a technician and Dr. Devita, an optometrist who worked in Dr. Chase's office at the time. Dr. DeVita did an initial examination of Mr. Augood's eyes and asked him what he was doing to manage his cataracts, assuming Mr. Augood was aware he had cataracts.

379. Dr. Chase then examined Mr. Augood and diagnosed him as having cataracts in both eyes. Dr. Chase drew a picture of Mr. Augood's cataracts in his medical chart. As recorded in Mr. Augood's medical records, they were described as dense central nuclear cortical (pp) cataracts in both eyes.

380. Dr. Chase measured Mr. Augood's Snellen vision as 20/40 in both eyes. His CST/BAT score was patch 2 and patch 3 on the 6 c/d column of the VectorVision test, which according to some measurements, was 60% below the bottom of the normal range and 85% to 90% below the average. Mr. Augood's CST/BAT score was worse in his right eye than in his left.

381. At the conclusion of his examination, Dr. Chase informed Mr. Augood that he had a cataract in each eye, and Respondent offered him surgery very soon. Mr. Augood was shocked. Respondent asked Mr. Augood if he wanted to hear about cataract surgery, and Mr. Augood responded that he did not. However, as he was about to leave, Mr. Augood asked Dr. Chase what he could do about his glare symptoms, Dr. Chase informed him that new glasses would not help his symptoms, and again asked Mr. Augood if he wanted to hear about cataract surgery. Mr. Augood, just wanting to get out of the office, indicated that he did.

382. Mr. Augood did not ask Dr. Chase about a second opinion, but Dr. Chase told him that there was no point getting a second opinion, because he was the only doctor in Vermont who was board certified to do the particular operation he was recommending. Mr. Augood was very surprised and shocked by this statement.

383. Recorded in Mr. Augood's medical records was the notation that the patient had been given a second opinion. There was conflicting evidence as to what this "second opinion" statement was. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion statements to this patient, and to his patients in general, is not credible. The Committee further finds that Dr. Chase suggested to Mr. Augood that a second opinion was of no use, and he bolstered this suggestion by telling Mr. Augood that he was the only physician in Vermont certified to perform this surgery. Dr. Chase's statements to Mr. Augood regarding a second opinion were confusing, misleading, and improper.

384. Also recorded in Mr. Augood's medical records was Respondent's notation that Mr. Augood wanted cataracts removed. Mr. Augood did not tell Respondent that he wanted his cataracts removed. Mr. Augood testified that the notation is not a true statement of what he wanted.

385. After the second time Respondent offered surgery to Mr. Augood, he then told Mr. Augood that he could go see the nurse to schedule the surgery. Mr. Augood then left Dr. Chase's examination lane. However, instead of going to see the nurse, Mr. Augood paid his bill and left Dr. Chase's office without telling Dr. Chase that he was not going to see the nurse and was not going to schedule cataract surgery.

386. Respondent did not engage in a thorough discussion with Mr. Augood regarding the information acquired about the condition of his eyes. He did not adequately discuss with him any of the information acquired from Mr. Augood or the results of the examination and tests of his eyes. Respondent did not discuss with him the potential risks and benefits to surgery, or any alternatives to surgery. Respondent did not discuss with Mr. Augood whether his vision was meeting his needs and the extent to which his vision may be compromising his quality of life.

387. Corroborating the lack of discussion between Respondent and Mr. Augood concerning any of these matters is the notation in Mr. Augood's chart that he wants cataracts removed. Although not a deliberate falsification, the notation was a misunderstanding or an overstatement that resulted in an inaccuracy. Had Respondent engaged in a meaningful discussion with his patient, Respondent would not have left the visit with the misunderstanding of Mr. Augood's intention and wouldn't have entered the misunderstanding in the chart.

388. Mr. Augood sought and received a second opinion from an optometrist, Dr. Dora Sudarsky, one week later on November 6, 2002. Dr. Sudarsky agreed with the refraction that Dr. Chase and his technicians had performed on Mr. Augood, as well as the resulting glasses prescription.

389. Dr. Sudarsky also diagnosed Mr. Augood as having cataracts in both eyes, with the right being worse than the left. She informed him that his cataracts were very small and looked like a spidery web of wispy veins that was fairly spread out across the front of his eye. She also told him that once his symptoms were bothering him, cataract surgery would be an appropriate treatment. She said that he should have surgery when he felt he was being bothered by his

cataracts.

390. Mr. Augood was examined by Dr. Thomas Cavin nearly a year later on October 6, 2003. Recorded in Mr. Augood's medical records regarding this visit was the notation that Mr. Augood was told over a year ago that he has cataracts, but notices no limitations due to them. Also recorded was the notation that Mr. Augood has some difficulty driving at night, but is more of a nuisance than a problem.

391. Dr. Cavin's technicians never performed a manual refraction of Mr. Augood and therefore never measured his best corrected visual acuity. Dr. Cavin did not perform any glare testing or any contrast sensitivity testing, on Mr. Augood.

392. If Mr. Augood had complained to Dr. Cavin that he was actually having trouble with glare on bright days and was "bothered" by glare, Dr. Cavin would have performed glare testing. If Dr. Cavin had concluded that the cataract he found was the cause of Mr. Augood's symptoms, he may have offered him surgery.

393. Dr. Cavin diagnosed Mr. Augood as having trace anterior subcapsular haze in both eyes and described the lens nucleus as clear. He further described them as very mild cataracts. His findings were not consistent with Respondent's diagnosis of dense central nuclear cortical cataracts. Dr. Cavin did not recommend that Mr. Augood have cataract surgery, because surgery was not medically necessary, was functioning quite well, and was happy with his vision.

394. Mr. Augood has never had cataract surgery and does not want surgery. He has no complaints about his vision, which is currently good. His glasses are meeting his visual needs. He is quality of life, such as work, driving a car, and being out in the sunshine, is not compromised by not having had cataract surgery.

395. Mr. Augood previously testified regarding his physician-patient relationship with Respondent under oath at court hearings and depositions. He was extensively cross-examined during his testimony at this hearing. A few inconsistencies appear when comparing all of his testimony related to this matter. The few inconsistencies are outweighed by his consistent ability to recall and testify about the details of his examination by Respondent. None of the inconsistencies establish that he is an unreliable witness as implied by Respondent. The Committee finds that he is a credible witness, who was able to accurately recollect and testify about his interactions with Respondent.

Jan Kerr (Patient # 14)

396. Jan Kerr testified on October 3, 2006. Dr. Chase examined Ms. Kerr once, on November 20, 2002.

397. In November, 2002, Jan Kerr was 52 years old, lived in Hinesburg, Vermont, and was employed as an operating room nurse at Fletcher Allen Health Care.

398. Ms. Kerr wore contact lenses to correct her vision, and she needed regular changes in her lens prescription.

399. In 2002, she noticed a decline in her vision, both near and far, and as a result she made

an appointment to see Dr. Chase on November 20, 2002.

400. At her November 20, 2002 examination, Ms. Kerr reported that she noticed a decrease in both her near and far vision, and on her Eye & Health History form she circled that she was currently experiencing decreased vision. She also reported that she was having difficulty seeing fine print, was having difficulty seeing small and fine objects in the operating room when the lights were dimmed (as they often were), and was having difficulty seeing to drive at night.

401. Ms. Kerr underwent extensive testing at Dr. Chase's office in several different exam rooms, and she feels that Dr. Chase gave her a very thorough exam. As recorded in Ms. Kerr's medical records, he diagnosed her as having dense central nuclear cortical lens opacities in both eyes.

402. Dr. Chase's medical records show that Jan Kerr received contrast sensitivity with glare testing both before and after dilation and each time she scored a patch 1 and patch 2. On the eye examination chart, in the section marked "V vision", the scores 20/100; 20/70 and 20/30; 20/30 both appear, and immediately below them is the score 20/100; 20/70 and it is expressly noted as being "CSTw/BAT." Ms. Kerr's contrast sensitivity, according to some measurements, was 73% below the bottom of the normal range for her age and 85% to 90% below the average.

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

404. Dr. Chase informed Ms. Kerr that she did have cataracts. She was shocked and surprised. He further told her that she should schedule the surgery as soon as possible. They briefly discussed cataracts and surgery, and she suggested that she might have a second opinion before she scheduled anything. Respondent told her that a second opinion wasn't necessary, because he

was the most qualified in the area and had received a particular certification for doing cataract surgery.

405. Recorded in Ms. Kerr's medical records was the notation that the patient was given a second opinion. There was conflicting evidence as to what this "second opinion" statement was. The Committee finds that Dr. Chase's explanation concerning his so-called second opinion statements to this patient, and to his patients in general, is not credible. The Committee further finds that Dr. Chase suggested to Ms. Kerr that a second opinion was of no use, and he bolstered this suggestion by telling Ms. Kerr that he was the most qualified physician in Vermont due to his certification to perform this surgery. Dr. Chase's statements to Ms. Kerr regarding a second opinion were confusing, misleading, and improper.

406. Also recorded in Ms. Kerr's medical records was Respondent's notation that she couldn't see to drive safely at night due to cataracts and wants cataracts removed. Ms. Kerr did not tell Dr. Chase or anyone in his office that she wanted cataracts removed. Ms. Kerr considers that notation to be false.

407. Dr. Chase suggested Jan Kerr visit with the scheduling nurse, and she did in fact meet and talk with the nurse without informing Dr. Chase that she did not want surgery. Dr. Chase's

nurse was polite and courteous and gave her written explanatory information regarding cataract surgery to take home with her.

408. Respondent did not engage in a thorough discussion with Ms. Kerr regarding the information acquired about the condition of her eyes. He did not adequately discuss with her any of the information acquired from Ms. Kerr or the results of the examination and tests of her eyes. Respondent did not discuss with her whether her contacts were meeting her visual needs or any alternatives to surgery. Respondent did not discuss with Ms. Kerr whether her vision was generally meeting her needs and the extent to which her vision may be compromising her quality of life.

409. Corroborating the lack of discussion between Respondent and Ms. Kerr concerning any of these matters is the notation in Ms. Kerr's chart that she couldn't see to drive safely at night due to cataracts and wants cataracts removed. Although not a deliberate falsification, the notation was a misunderstanding or an overstatement that resulted in an inaccuracy. Had Respondent engaged in a meaningful discussion with his patient, Respondent would not have left the visit with the misunderstanding of Ms. Kerr's intention and wouldn't have entered the misunderstanding in the chart.

410. During the meeting with Dr. Chase's nurse, Ms. Kerr said she wanted to defer making any decision about cataract surgery until after she had an opportunity to speak to her husband, who had previously had cataract surgery from Dr. Chase with a very successful outcome.

411. On January 15, 2003, Jan Kerr saw Dr. Irwin for a second opinion regarding her cataracts. Dr. Irwin's medical records indicate that Ms. Kerr reported that the quality of her vision was poor at night and in dim light, and when working in the OR, if lights are turned down, it is a mild problem.

412. During this examination, Ms. Kerr's visual acuity, with her contacts in, was 20/20 in her right eye and 20/40 in her left eye. Without her contacts in, she was refracted to 20/20 in both eyes. When tested with the BAT, her right eye was 20/60 and her left eye was 20/20.

413. Dr. Irwin diagnosed Ms. Kerr as having a trace of nuclear and cortical cataracts in both eyes. He described them as early and felt quite strongly that she did not need surgery, because after discussing the situation at great length, they concluded that there was no problem with her vision. What Dr. Irwin found was not consistent with Respondent's earlier diagnosis of dense central nuclear cortical cataract.

414. Dr. Irwin then referred Ms. Kerr to Dr. Guilfoy, another ophthalmologist, to receive a new contact lens prescription because Dr. Guilfoy was an expert in prescribing contact lenses. Ms. Kerr also asked Dr. Guilfoy for a second opinion whether she should have cataract surgery.

415. Dr. Guilfoy first examined Ms. Kerr on February 19, 2003. He determined her visual acuity to be 20/13 with corrective lenses. He described her vision as excellent. Dr. Guilfoy may not have taken a complete history of her vision symptoms. He limited his exam because Ms. Kerr had received full exams from Dr. Irwin and Dr. Chase in the preceding few months.

416. Dr. Guilfoy described Ms. Kerr's lens as within normal limits as he did not see a cataract. Consequently, he did not diagnose Ms. Kerr with cataracts. He did not believe Ms. Kerr needed

cataract surgery and did not recommend it, because she had no visible cataracts and her visual acuity was excellent. If she had a dense central nuclear cortical cataract, he would have seen it, because a nuclear cataract is central to the lens and is easily visible, even in an undilated state. Such a cataract would not correlate to 20/13 vision. This evidence is not consistent with Dr. Chase's diagnosis and description of a dense central nuclear cortical cataract after Respondent's examination of Ms. Kerr's eyes in 2002.

417. Ms. Kerr has never wanted cataract surgery and has never had it. Ms. Kerr has had to change her contact lens prescription several times. While she sometimes has a problem with glare, her contact lenses provide her with satisfactory visual function. Her quality of life has not been compromised by not having cataract surgery.

418. Ms. Kerr previously testified regarding her physician-patient relationship with Respondent under oath at court hearings and depositions. She was extensively cross-examined during her testimony at this hearing. A few inconsistencies appear when comparing all of her testimony related to this matter. The few inconsistencies are outweighed by her consistent ability to recall and testify about the details of her contact with Respondent. The Committee finds that she is a credible witness, who is able to accurately recollect and testify about her interactions with Respondent.

CONCLUSIONS OF LAW

Helena Nicolay Nordstrom (Patient # 1)
Count I

1. The State has charged that Respondent's recommendation to Complainant that she undergo cataract surgery when there was no evidence of cataract formation constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count VII). The Committee concludes that Respondent's conduct regarding his diagnosis of cataract formation and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count I does not constitute unfitness to practice medicine.

Count II

2. The State has charged that Respondent's direction to Ms. Nordstrom that she not seek a second opinion constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count VIII). The Committee concludes that while this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b), Respondent's actions are best addressed under those sections. The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count II does not constitute unfitness to practice medicine.

Count III

3. The State has charged that Respondent's falsification of the Complainant's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count VI) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count IX). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Ms. Nordstrom's medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count IV

4. The State has charged that Respondent's testing of the Complainant's vision after dilation in order to support his recommendation for cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). Based on the record, and conflicting testimony of the witnesses, the Committee concludes that Respondent did not use post-dilation tests to support a recommendation for cataract surgery in violation of this section.

Count V

5. The State has charged that Respondent's recommendation to Complainant that she undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count VI

6. The State has charged that Respondent's falsification of the Complainant's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count VII

7. The State has charged that Respondent's recommendation to Complainant that she undergo cataract surgery when there was no evidence of cataract formation constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count I above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count VII.

Count VIII

8. The State has charged that Respondent's direction to the Complainant that she not seek a second opinion constitutes immoral, unprofessional or dishonorable conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count II above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct, as it relates to the professional work of licensed physicians, is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Respondent's statements made to this patient regarding whether she should obtain a second opinion about the condition of her eyes and cataract surgery were misleading, confusing, and improper, and were made at a time when this patient was vulnerable and concerned about her eyes. Respondent's actions in this instance fall below the personal and moral standards required under 26 V.S.A. § 1398 and constitute a violation of this statute.

Count IX

9. The State has charged that Respondent's falsification of the Complainant's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts III and VI above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count IX.

Count X

10. The State has charged that Respondent's testing of the Complainant's vision after dilation in order to support his recommendation for cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. As in Count IV, after careful consideration of all the evidence, the Committee concludes that Respondent did not use post-dilation tests to support a recommendation for cataract surgery in violation of this section. The Committee finds no violation under Count X.

Count XI

11. Respondent's treatment of the Complainant on January 17, 2003 constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). Seeing her for the first time, he described dense cataracts that could not be seen during prior or subsequent examinations by different eye care professionals, and he recommended cataract surgery on that basis. The fact that other eye care professionals found no evidence of any cataract formation contradicts Respondent's diagnosis. His use of the term "dense" is not in line with the general understanding of the descriptive use of that term or with AAO PPP characterization of dense cataracts. In addition, Respondent's failure to thoroughly and adequately discuss with her whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and his statements to Ms. Nordstrom and the notation in her medical records regarding a second opinion support our conclusion that his treatment of Ms. Nordstrom was a gross failure to meet the required standard of care.

Count XII

12. Respondent's treatment of the Complainant on January 17, 2003, also exhibits both (a) a performance of unacceptable patient care and (b) a failure to conform to the essential standards of acceptable and prevailing practice and thereby constitutes a failure to practice competently under 26 V.S.A. § 1354(b). Seeing her for the first time, he described dense cataracts that could not be seen during prior or subsequent examinations by different eye care professionals, and he recommended cataract surgery on that basis. The fact that other eye care professionals found no evidence of any cataract formation contradicts Respondent's diagnosis. His use of the term "dense" is not in line with the general understanding of the descriptive use of that term or with

AAO PPP characterization of dense cataracts. In addition, Respondent's failure to thoroughly and adequately discuss with her whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and his statements to Ms. Nordstrom and the notation in her medical records regarding a second opinion support our conclusion that his treatment of Ms. Nordstrom was a failure to practice competently.

Judith Salatino (Patient #2)

Count XIII

13. The State has charged that Respondent's recommendation to Patient #2 that she undergo cataract surgery when there was only a bare trace of cataract formation constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XIX). The Committee concludes that Respondent's conduct regarding his diagnosis and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count XIII does not constitute unfitness to practice medicine.

Count XIV

14. The State has charged that the unnecessary cataract extraction performed on Patient #2's right eye constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The evidence does not support the allegation that the cataract extraction was unnecessary; therefore, there is no violation under this count.

Count XV

15. The State has charged that Respondent's falsification of Patient #2's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #2, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count XVIII) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XXI). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Ms. Salatino's medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b), Respondent's actions are best addressed under those sections. The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count XVI

16. The State has charged that Respondent's testing of Patient 2's vision after dilation in order to support his recommendation for cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). Based on the record, and conflicting testimony from the witnesses, the Committee concludes that Respondent did not use post-dilation tests to support a recommendation for cataract surgery in violation of this section.

Count XVII

17. The State has charged that Respondent's recommendation to Patient #2 that she undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count XVIII

18. The State has charged that Respondent's falsification of Patient #2's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count XIX

19. The State has charged that Respondent's recommendation to Patient #2 that she undergo cataract surgery when there existed only a bare trace of cataract formation constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count XIII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count XIX.

Count XX

20. The State has charged that the unnecessary cataract extraction performed on Patient #2's right eye constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. The same factual allegations form the basis for Count XIV above, and as the Committee concluded in Count XIV, the evidence does not support the allegation that the cataract extraction was unnecessary; therefore, there is no violation under Count XX.

Count XXI

21. The State has charged that Respondent's falsification of Patient #2's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts XV and XVIII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee

concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count XXI.

Count XXII

22. The State has charged that Respondent's testing of Patient 2's vision after dilation in order to support his recommendation for cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. The same factual allegations form the basis for Count XVI above. As the Committee concluded in that Count, based on the record and conflicting testimony from the witnesses, Respondent did not use post-dilation tests to support a recommendation for cataract surgery. Consequently, there is no violation under Count XXII.

Count XXIII

23. Respondent's treatment of Ms. Salatino constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). He described that she had dense central nuclear cortical cataracts. Subsequent eye examinations and findings contradict Respondent's diagnosis. His use of the term "dense" is not in line with the general understanding of the descriptive use of that term or with AAO PPP characterization of dense cataracts. In addition, Respondent's failure to thoroughly and adequately discuss with Ms. Salatino whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and his statements to Ms. Salatino and the notation in her medical records regarding a second opinion support our conclusion that his treatment of Ms. Salatino was a gross failure to meet the required standard of care.

Count XXIV

24. Respondent's treatment of the Complainant also exhibits both (a) a performance of unacceptable patient care and (b) a failure to conform to the essential standards of acceptable and prevailing practice and thereby constitutes a failure to practice competently under 26 V.S.A. § 1354(b). He described that she had dense central nuclear cortical cataracts. Subsequent eye examinations and findings contradict Respondent's diagnosis. His use of the term "dense" is not in line with the general understanding of the descriptive use of that term or with AAO PPP characterization of dense cataracts. In addition, Respondent's failure to thoroughly and adequately discuss with her whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and his statements to Ms. Salatino and the notation in her medical records regarding a second opinion support our conclusion that his treatment of Ms. Salatino was a failure to practice competently.

Susan Lang (Patient #4)
Count XXV

25. The State has charged that Respondent's recommendation to Patient #4 that she undergo cataract surgery when cataracts were visually insignificant constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this

conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XXII). The Committee concludes that Respondent's conduct regarding his diagnosis of cataract formation and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count XXV does not constitute unfitness to practice medicine.

Count XXVI

26. The State has charged that the unnecessary cataract extraction performed on Patient #4's right eye constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The evidence does not support the allegation that the cataract extraction was unnecessary; therefore, there is no violation under this count.

Count XXVII

27. The State has charged that Respondent's falsification of Patient #4's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #2, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count XXXI) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XXXIV). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Ms. Lang's medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count XXVIII

28. The State has charged that Respondent's direction to Patient #4 that she not seek a second opinion constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XXXVI). The Committee concludes that while this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b), Respondent's actions are best addressed under those sections. The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count XXVIII does not constitute unfitness to practice medicine.

Count XXIX

29. The State has charged that Respondent's testing of Patient 4's vision after dilation in order to support his recommendation for cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). Based on the record, and conflicting testimony from the witnesses, the Committee concludes that Respondent did not use post-dilation tests to support a recommendation for cataract surgery in violation of this section.

Count XXX

30. The State has charged that Respondent's recommendation to Patient #4 that she undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count XXXI

31. The State has charged that Respondent's falsification of Patient #4's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count XXXII

32. The State has charged that Respondent's recommendation to Patient #4 that she undergo cataract surgery when there was no visually significant cataract formation constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count XXV above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count XXXII.

Count XXXIII

33. The State has charged that the unnecessary cataract extraction performed on Patient #4's right eye constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. The same factual allegations form the basis for Count XXVI above, and as the Committee concluded in Count XIV, the evidence does not support the allegation that the cataract extraction was unnecessary; therefore, there is no violation under Count XXXIII.

Count XXXIV

34. The State has charged that Respondent's falsification of Patient #4's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts XXVII and XXXI above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best

addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count XXXIV.

Count XXXV

35. The State has charged that Respondent's testing of Patient 4's vision after dilation in order to support his recommendation for cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. The same factual allegations form the basis for Count XXIX above. As the Committee concluded in that Count, based on the record and conflicting testimony from the witnesses, Respondent did not use post-dilation tests to support a recommendation for cataract surgery. Consequently, there is no violation under Count XXXV.

Count XXXVI

36. The State has charged that Respondent's direction to Patient 4 that she not seek a second opinion constitutes immoral, unprofessional or dishonorable conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count XVIII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct, as it relates to the professional work of licensed physicians, is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Respondent's statements made to this patient regarding whether she should obtain a second opinion about the condition of her eyes and cataract surgery were misleading, confusing, and improper, and were made at a time when this patient was vulnerable and concerned about her eyes. Respondent's actions in this instance fall below the personal and moral standards required under 26 V.S.A. § 1398 and constitute a violation of this statute.

Count XXXVII

37. Respondent's treatment of Ms. Lang constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). He described that she had dense central nuclear cortical pp cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His use of the term "dense" is not in line with the general understanding of the descriptive use of that term or with AAO PPP characterization of dense cataracts. In addition, Respondent's failure to thoroughly and adequately discuss with Ms. Lang whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and his statements to Ms. Lang and the notation in her medical records regarding a second opinion support our conclusion that his treatment of Ms. Lang was a gross failure to meet the required standard of care.

Count XXXVIII

38. Respondent's treatment of Ms. Lang also exhibits both (a) a performance of unacceptable patient care and (b) a failure to conform to the essential standards of acceptable and prevailing practice and thereby constitutes a failure to practice competently under 26 V.S.A. § 1354(b). He described that she had dense central nuclear cortical pp cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His use of the term "dense" is not in line with

the general understanding of the descriptive use of that term or with AAO PPP characterization of dense cataracts. In addition, Respondent's failure to thoroughly and adequately discuss with her whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and his statements to Ms. Lang and the notation in her medical records regarding a second opinion support our conclusion that his treatment of Ms. Lang was a failure to practice competently.

Marylen Grigas (Patient #5)
Count XXXIX

39. The State has charged that Respondent's recommendation to Patient #5 that she undergo cataract surgery when cataracts were clinically insignificant constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XLIV). The Committee concludes that Respondent's conduct regarding his diagnosis of cataract formation and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count XXXIX does not constitute unfitness to practice medicine.

Count XL

40. The State has charged that Respondent's pressuring of Patient #5 to undergo unnecessary cataract surgery when this patient had reservations about such surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The evidence does not support the allegation that Respondent's conduct amounted to pressuring Ms. Grigas to have surgery; therefore, there is no violation under this count.

Count XLI

41. The State has charged that Respondent's falsification of Patient #5's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #5, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count XLIII) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XLVI). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Ms. Grigas' medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count XLII

42. The State has charged that Respondent's recommendation to Patient #5 that she undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count XLIII

43. The State has charged that Respondent's falsification of Patient #5's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count XLIV

44. The State has charged that Respondent's recommendation to Patient #5 that she undergo cataract surgery when cataracts were clinically insignificant constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count XXXIX above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count XLIV.

Count XLV

45. The State has charged that Respondent's pressuring of Patient #5 to undergo unnecessary cataract surgery when this patient had reservations about such surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. The same factual allegations form the basis for Count XL above, and as the Committee concluded in Count XL, the evidence does not support the allegation that Respondent's conduct amounted to pressuring Patient 5 to have surgery; therefore, there is no violation under Count XLV.

Count XLVI

46. The State has charged that Respondent's falsification of Patient #5's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts XLI and XLIII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count XLVI.

Count XLVII

47. Respondent's treatment of Ms. Grigas constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). He described that she had dense central nuclear cortical cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Ms. Grigas whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and the notation in her medical record regarding a second opinion, support our conclusion that his treatment of Ms. Grigas was a gross failure to meet the required standard of care.

Count XLVIII

48. Respondent's treatment of Ms. Grigas also exhibits both (a) a performance of unacceptable patient care and (b) a failure to conform to the essential standards of acceptable and prevailing practice and thereby constitutes a failure to practice competently under 26 V.S.A. § 1354(b). He described that she had dense central nuclear cortical cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Ms. Grigas whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and the notation in her medical records regarding a second opinion, support our conclusion that his treatment of Ms. Grigas was a failure to practice competently.

Donald Olson (Patient #7)

Count XLIX

49. The State has charged that Respondent's recommendation to Patient #7 that he undergo cataract surgery when this patient's cataract formations were of no visual significance constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LII). The Committee concludes that the evidence is not clear as to any recommendation of surgery made by Respondent to Patient #7; therefore, the Committee concludes that there is no violation under Count XLIX.

Count L

50. The State has charged that Respondent's statement to Patient #7 that his cataracts were in an advanced state to support his recommendation to this patient for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LIII). As concluded above, the evidence is not clear as to any recommendation of surgery made by Respondent to Patient #7; therefore, the Committee concludes that there is no violation under Count L.

Count LI

51. The State has charged that Respondent's recommendation to Patient #7 that he undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). As concluded above, the evidence is not clear as to any recommendation of surgery made by Respondent to Patient #7; therefore, the Committee concludes that there is no violation under Count L.

Count LII

52. The State has charged that Respondent's recommendation to Patient #7 that he undergo cataract surgery when this patient's cataract formation was of no particular visual significance constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 . As concluded above, the evidence is not clear as to any recommendation of surgery made by Respondent to Patient #7; therefore, the Committee concludes that there is no violation under Count LII.

Count LIII

53. The State has charged that Respondent's representation to Patient #7 that his cataracts were in an advanced state to support his recommendation that this patient undergo unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. As concluded above, the evidence is not clear as to any recommendation of surgery made by Respondent to Patient #7; therefore, the Committee concludes that there is no violation under Count LIII.

Count LIV

54. The evidence does not support the allegation that Respondent's treatment of Patient #7 constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). Respondent did not describe Mr. Olson's cataracts as dense. The evidence does not establish that any second opinion statement was given or that surgery was even discussed. The Committee thus concludes that there is no violation under Count LIV.

Jane Corning (Patient #8)
Count LV

55. The State has charged that Respondent's recommendation to Patient #8 that she undergo cataract surgery when there was only the very earliest traces of cataract formation constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LIX). The Committee concludes that Respondent's conduct regarding his diagnosis of cataract formation and subsequent recommendations is best addressed

as unprofessional conduct under 26 V.S.A. § 1354(a)(22). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count LV does not constitute unfitness to practice medicine.

Count LVI

56. The State has charged that Respondent's falsification of Patient #8's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #8, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count LVIII) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LX). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Ms. Corning's medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count LVII

57. The State has charged that Respondent's recommendation to Patient #8 that she undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count LVIII

58. The State has charged that Respondent's falsification of Patient #8's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count LIX

59. The State has charged that Respondent's recommendation to Patient #8 that she undergo cataract surgery when there existed only the very earliest traces of cataract formation constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count LV above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count LIX.

Count LX

60. The State has charged that Respondent's falsification of Patient #8's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts LVI and LVIII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count LX.

Count LXI

61. Respondent's treatment of Jane Corning constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). He described that she had dense central nuclear cortical cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Ms. Corning whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and the notation in her medical records regarding a second opinion, support our conclusion that his treatment of Jane Corning was a gross failure to meet the required standard of care.

Count LXII - LXIX

Counts LXII – LXIX in relation to Patient #9 were dismissed by the State on September 11, 2006.

Franklin Cole (Patient #10)
Count LXX

62. The State has charged that Respondent's recommendation to Patient #10 that he undergo cataract surgery when there was only a trace of cataract formation measured as 1+ constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LXXVI). The Committee concludes that Respondent's conduct regarding his diagnosis and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count LV does not constitute unfitness to practice medicine.

Count LXXI

63. The State has charged that Respondent's diagnosis and treatment of glaucoma for Patient #10 when that patient had no glaucoma constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #10, the State has also charged that this conduct constitutes willful misrepresentation of treatment under 26 V.S.A. § 1354(a)(14) (Count LXXIV); and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LXXVII). The Committee concludes that Respondent's regarding his diagnosis and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count LXXI does not constitute unfitness to practice medicine.

Count LXXII

64. The State has charged that Respondent's falsification of Patient #10's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #10, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count LXXV) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LXXVIII). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Mr. Cole's medical records are not deliberate falsifications and concluded that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count LXXIII

65. The State has charged that Respondent's recommendation to Patient #10 that he undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count LXXIV

66. The State has charged that Respondent's diagnosis and treatment of glaucoma for Patient #10 when that patient did not have glaucoma constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count LXXV

67. The State has charged that Respondent's falsification of Patient #10's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count LXXVI

68. The State has charged that Respondent's recommendation to Patient #10 that he undergo cataract surgery when there existed only a trace of cataract formation measured at 1+ constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count LXX above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count LXXVI.

Count LXXVII

69. The State has charged that Respondent's diagnosis and treatment of glaucoma for Patient #10 when that patient did not have glaucoma constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts LXXI and LXXIV above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count LXXVII.

Count LXXVIII

70. The State has charged that Respondent's falsification of Patient #10's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts LXXII and LXXV above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count LXXVIII.

Count LXXIX

71. Respondent's treatment of Franklin Cole constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). Respondent diagnosed Mr. Cole as having glaucoma

and treated it for several years. He also diagnosed Mr. Cole with central nuclear cortical posterior subscapular cortical cataracts in both eyes. Subsequent eye examinations contradict both of Respondent's diagnoses. The Committee concludes that Respondent's recommendation to Mr. Cole that he should have surgery for glaucoma and cataracts surgery, in conjunction with Respondent's failure to thoroughly and adequately discuss with Mr. Cole whether his vision, with or without glasses or contact lenses, was meeting his needs or whether his quality of life was being compromised as a result of his vision, is a gross departure from the proper standard of care. In addition, Respondent's statements to Mr. Cole regarding a second opinion support our conclusion that his treatment of Franklin Cole was a gross failure to meet the required standard of care.

Margaret McGowan (Patient #11)
Count LXXX

72. The State has charged that Respondent's recommendation to Patient #11 that she undergo cataract surgery when there was only a bare trace of cataract formation constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14) (Count LXXXIII) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LXXXV). The Committee concludes that Respondent's conduct regarding his diagnosis of cataract formation and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count LXXX does not constitute unfitness to practice medicine.

Count LXXXI

73. The State has charged that the unnecessary cataract extraction performed on Patient #11's right eye constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The evidence does not support the allegation that the cataract extraction was unnecessary; therefore, there is no violation under this count.

Count LXXXII

74. The State has charged that Respondent's falsification of Patient #11's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #11, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count LXXXIV) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count LXXXVII). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Ms. McGowan's medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the

Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count LXXXIII

75. The State has charged that Respondent's recommendation to Patient #11 that she undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count LXXXIV

76. The State has charged that Respondent's falsification of Patient #11's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count LXXXV

77. The State has charged that Respondent's recommendation to Patient #11 that she undergo cataract surgery when there existed only a bare trace of cataract formation constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count LXXX above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count LXXXV.

Count LXXXVI

78. The State has charged that the unnecessary cataract extraction performed on Patient #11's right eye constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. The same factual allegations form the basis for Count LXXXI above, and as the Committee concluded in Count LXXXI, the evidence does not support the allegation that the cataract extraction was unnecessary; therefore, there is no violation under Count LXXXVI.

Count LXXXVII

79. The State has charged that Respondent's falsification of Patient #2's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts LXXXII and LXXXIV above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count LXXXVII.

Count LXXXVIII

80. Respondent's treatment of Ms. McGowan constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). He described that she had dense central nuclear cortical cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Ms. McGowan whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and his statements to Ms. McGowan and the notations in her medical records regarding a second opinion, support our conclusion that his treatment of Ms. McGowan was a gross failure to meet the required standard of care.

Count LXXXIX

81. Respondent's treatment of the Complainant exhibits both (a) a performance of unacceptable patient care and (b) a failure to conform to the essential standards of acceptable and prevailing standards and thereby constitutes a failure to practice competently under 26 V.S.A. § 1354(b). He described that she had dense central nuclear cortical cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Ms. McGowan whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and his statements to Ms. McGowan and the notations in her medical records regarding a second opinion, support our conclusion that his treatment of Ms. McGowan was a failure to practice competently.

Joseph Touchette (Patient #12)

Count XC

82. The State has charged that Respondent's recommendation to Patient #12 that he undergo cataract surgery when there was only a trace of cataract formation constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14) (Count XCII) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XCIV). The Committee concludes that Respondent's conduct regarding his diagnosis of cataract formation and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count XC does not constitute unfitness to practice medicine.

Count XCI

83. The State has charged that Respondent's falsification of Patient #12's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #12, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count XCIII) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count XCV). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Mr. Touchette's medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count XCII

84. The State has charged that Respondent's recommendation to Patient #12 that he undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count XCIII

85. The State has charged that Respondent's falsification of Patient #12's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count XCIV

86. The State has charged that Respondent's recommendation to Patient #12 that he undergo cataract surgery when there existed only a trace of cataract formation constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count XC above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count XCIV.

Count XCV

87. The State has charged that Respondent's falsification of Patient #12's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions

set forth under Counts XC and XCIII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count XCV.

Count XCVI

88. Respondent's treatment of Mr. Touchette constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). He described that this patient had dense central nuclear cortical cataracts, right eye greater than left eye. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Mr. Touchette whether his vision, with or without glasses or contact lenses, was meeting his needs or whether his quality of life was being compromised as a result of his vision, and Respondent's statements to Mr. Touchette and the notation in his medical records regarding a second opinion, support our conclusion that Respondent's treatment of Mr. Touchette was a gross failure to meet the required standard of care.

William Augood Pierson (Patient #13)

Count XCVII

89. The State has charged that Respondent's recommendation to Patient #13 that he undergo cataract surgery when no such surgery was indicated constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count CIII). The Committee concludes that Respondent's conduct regarding his diagnosis of cataract formation and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22) and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count XC does not constitute unfitness to practice medicine.

Count XCVIII

90. The State has charged that Respondent's insistence that Patient #13 undergo cataract surgery, without discussing alternatives to surgery, and when Patient #13 indicated he did not want surgery, constitutes conduct which evidences unfitness to practice medicine under 26

V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count CIV). The Committee concludes that Respondent's conduct regarding his diagnosis and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22) and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count XCVIII does not constitute unfitness to practice medicine.

Count XCIX

91. The State has charged that Respondent's falsification of Patient #13's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #13, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count CII) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count CV). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Mr. Pierson's medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count C

92. The State has charged that Respondent's attempt to discourage Patient #13 from obtaining a second opinion constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count CVI). The Committee concludes that while this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(22), and failure to practice competently under 26 V.S.A. § 1354(b), Respondent's actions are best addressed under those sections. The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count C does not constitute unfitness to practice medicine.

Count CI

93. The State has charged that Respondent's recommendation to Patient #13 that he undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count CII

94. The State has charged that Respondent's falsification of Patient #13's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count CIII

95. The State has charged that Respondent's recommendation to Patient #13 that he undergo cataract surgery when no such surgery was indicated constitutes conduct which evidences constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count XCVII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count CIII.

Count CIV

96. The State has charged that Respondent's insistence that Patient #13 undergo cataract surgery, without discussing alternatives to surgery, and when Patient #13 indicated he did not want surgery, constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count XCVIII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count CIV.

Count CV

97. The State has charged that Respondent's falsification of Patient #13's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts XCIX and CII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count CV.

Count CVI

98. The State has charged that Respondent's attempt to discourage Patient #13 from obtaining a second opinion constitutes immoral, unprofessional or dishonorable conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count C above, to the extent the

Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct, as it relates to the professional work of licensed physicians, is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Respondent's statements made to this patient regarding whether he should obtain a second opinion about the condition of his eyes and cataract surgery were misleading, confusing, and improper, and were made at a time when this patient was vulnerable and concerned about his eyes. Respondent's actions in this instance fall below the personal and moral standards required under 26 V.S.A. § 1398 and constitute a violation of this statute.

Count CVII

99. Respondent's treatment of Mr. Pierson constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). He described that this patient had dense central nuclear cortical pp cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Mr. Pierson whether his vision, with or without glasses or contact lenses, was meeting his needs or whether his quality of life was being compromised as a result of his vision, and Respondent's statements to Mr. Augood and the notation in his medical records regarding a second opinion, support our conclusion that Respondent's treatment of Mr. Pierson was a gross failure to meet the required standard of care.

Count CVIII

100. Respondent's treatment of the Complainant exhibits both (a) a performance of unacceptable patient care and (b) a failure to conform to the essential standards of acceptable and prevailing standards and thereby constitutes a failure to practice competently under 26 V.S.A. § 1354(b). He described that this patient had dense central nuclear cortical pp cataracts in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Mr Pierson whether his vision, with or without glasses or contact lenses, was meeting his needs or whether his quality of life was being compromised as a result of his vision, and Respondent's statements to Mr. Augood and the notation in his medical records regarding a second opinion, support our conclusion that Respondent's treatment of Mr. Pierson was a failure to practice competently.

Jan Kerr (Patient #14)
Count CIX

101. The State has charged that Respondent's recommendation to Patient #14 that she undergo cataract surgery when there was only the early traces of cataract formation constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The Committee

concludes that Respondent's conduct regarding his diagnosis of cataract formation and subsequent recommendations is best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22) and failure to practice competently under 26 V.S.A. § 1354(b). The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count CIX does not constitute unfitness to practice medicine.

Count CX

102. The State has charged that Respondent's attempt to discourage Patient #14 from obtaining a second opinion constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). The State has also charged that this conduct constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count CXV). The Committee concludes that while this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(22) and failure to practice competently under 26 V.S.A. § 1354(b), Respondent's actions are best addressed under those sections. The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in Count C does not constitute unfitness to practice medicine.

Count CXI

103. The State has charged that Respondent's falsification of Patient #14's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes conduct which evidences unfitness to practice medicine under 26 V.S.A. § 1354(a)(7). With respect to Patient #14, the State has also charged that this conduct constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8) (Count CXIII) and immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398 (Count CXVI). The Committee has found that the inaccuracies, misunderstandings, or overstatements present in Ms. Kerr's medical records are not deliberate falsifications and concludes that those actions are best addressed as unprofessional conduct under 26 V.S.A. § 1354(a)(22) and failure to practice competently under 26 V.S.A. § 1354(b), Respondent's actions are best addressed under those sections. The several statutes that the State has charged Respondent with having violated set forth different categories of unprofessional conduct and serve different functions. Delozier v. State, 160 Vt. 426, 432-433 (1993). Based on the entire record of this case, the Committee concludes that Respondent's conduct as alleged in this count does not constitute unfitness to practice medicine.

Count CXII

104. The State has charged that Respondent's recommendation to Patient #14 that she undergo unnecessary cataract surgery constitutes willful misrepresentation in treatment under 26 V.S.A. § 1354(a)(14). Based on the entire record, the Committee concludes that Respondent's actions did not amount to a willful misrepresentation in treatment in violation of this section.

Count CXIII

105. The State has charged that Respondent's falsification of Patient #14's medical records to support his recommendation to this Complainant for unnecessary cataract surgery constitutes unprofessional conduct under 26 V.S.A. § 1354(a)(8). Based on the entire record, the Committee concludes that Respondent did not willfully make and file a false report or records in his practice as a physician in violation of this section.

Count CXIV

106. The State has charged that Respondent's recommendation to Patient #14 that she undergo cataract surgery when there existed only the early stages of cataract formation constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count CIX above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count CXIV.

Count CXV

107. The State has charged that Respondent's attempt to discourage Patient #14 from obtaining a second opinion constitutes immoral, unprofessional or dishonorable conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Count CX above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct, as it relates to the professional work of licensed physicians, is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Respondent's statements made to this patient regarding whether she should obtain a second opinion about the condition of her eyes and cataract surgery were misleading, confusing, and improper, and were made at a time when this patient was vulnerable and concerned about her eyes. Respondent's actions in this instance fall below the personal and moral standards required under 26 V.S.A. § 1398 and constitute a violation of this statute.

Count CXVI

108. The State has charged that Respondent's falsification of Patient #14's medical records to support his recommendation to Complainant for unnecessary cataract surgery constitutes immoral, unprofessional or dishonest conduct under 26 V.S.A. § 1398. Based on the conclusions set forth under Counts CXI and CXIII above, to the extent the Committee has concluded that Respondent's actions fell below the required standard of care, Respondent's conduct is best addressed under 26 V.S.A. § 1354(a)(22) and 26 V.S.A. § 1354(b). Furthermore, the Committee concludes that Respondent's conduct alleged under this count is not immoral or dishonest. The Committee finds no violation under Count CXVI.

Count CXVII

109. Respondent's treatment of Jan Kerr constitutes a gross failure to use on a particular occasion 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 under 26 V.S.A. § 1354(a)(22). Respondent described that this patient had dense central nuclear cortical lens opacities in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with his patient whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and Respondent's statements to Ms. Kerr and the notation in her medical records regarding a second opinion, support our conclusion that Respondent's treatment of Jan Kerr was a gross failure to meet the required standard of care.

Count CXVIII

110. Respondent's treatment of the Complainant exhibits both (a) a performance of unacceptable patient care and (b) a failure to conform to the essential standards of acceptable and prevailing standards and thereby constitutes a failure to practice competently under 26 V.S.A. § 1354(b). Respondent described that this patient had dense central nuclear cortical lens opacities in both eyes. Subsequent eye examinations contradict Respondent's diagnosis. His 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. In addition, Respondent's failure to thoroughly and adequately discuss with Jan Kerr whether her vision, with or without glasses or contact lenses, was meeting her needs or whether her quality of life was being compromised as a result of her vision, and Respondent's statements to Ms. Kerr and the notation in her medical records regarding a second opinion, support our conclusion that Respondent's treatment of Jan Kerr was a failure to practice competently.

JUDGMENT AND ORDER
ON CHARGES OF UNPROFESSIONAL CONDUCT

Based upon the evidence in the record and the resulting Findings of Fact and Conclusions of Law, IT IS ORDERED BY THE BOARD that:

1. Counts I-VII, IX, X, XIII-XXII, XXV-XXXV, XXXIX-XLVI, XLIX-LX, LXII-LXXVIII, LXXX-LXXXVII, XC-XCV, XCVII-CV, CIX-CXIV, and CXVI are dismissed.

2. Respondent has committed unprofessional conduct as charged in Counts VIII, XI, XII, XXIII, XXIV, XXXVI, XXXVII, XXXVIII, XLVII, XLVIII, LXI, LXXIX, LXXXVIII, LXXXIX, XCVI, CVI, CVII, CVIII, CXV, CXVII, CXVIII.

3. Having deliberated and rendered judgment regarding the charges of unprofessional conduct, the Board reaches the stage at which disciplinary action may be imposed on Respondent's license. The Board requests that within 30 days of the date of entry of this Judgment and Order, the parties submit written memorandum outlining their positions as to what disciplinary action, if any, should be imposed by the Board.

THE BOARD:

Sharon L. Nicol, Public Member — Date 12/5/07

Alexander Northern, Public Member — Date 12/5/07

James D. Cahill, M.D., Physician Member — Date 12/5/07

Toby Sadkin, M.D., Physician Member — Date 12/10/07

Hon. Hilton H. Dier, Jr., Ad Hoc Member — Date 12/6/07

Filed with Board Office: — Date December 10, 2007

Date of Entry: December 10, 2007