

**STATE OF VERMONT  
BOARD OF MEDICAL PRACTICE**

<b>In re:</b>	)	<b>MPC 15-0203</b>	<b>MPC 110-0803</b>
	)	<b>MPC 208-1003</b>	<b>MPC 163-0803</b>
<b>David S. Chase,</b>	)	<b>MPC 148-0803</b>	<b>MPC 126-0803</b>
	)	<b>MPC 106-0803</b>	<b>MPC 209-1003</b>
<b>Respondent.</b>	)	<b>MPC 122-0803</b>	<b>MPC 89-0703</b>
	)		<b>MPC 90-0703</b>
	)		<b>MPC 87-0703</b>

**DR. CHASE’S PROFFER OF WITNESS TESTIMONY  
AND SUMMARY EXHIBITS**

Respondent, Dr. David S. Chase, presents the following proffer of the testimony of Ellen Flanagan and Brianne Chase, as well as summary exhibits that Dr. Chase intends to introduce into evidence on January 30, 2007. Dr. Chase requests that he be allowed to present all of this evidence at the hearing.

**I. Introduction.**

On December 18, 2005, the Board excluded as “marginally relevant” some of the proposed testimony of two of Respondent’s witnesses, Ellen Flanagan and Brianne Chase. Prior to ruling, the Board asked Respondent’s counsel to provide an oral proffer of their testimony. While counsel provided an oral proffer at that time, it was necessarily limited in its scope and did not recount all of the witnesses’ expected testimony. In order to make certain that the record of this case accurately and fully reflects their proposed testimony, Respondent submits the following written proffer, along with the witnesses’ sworn testimony from Dr. Chase’s federal trial.<sup>1</sup> That sworn testimony is consistent with the testimony they would provide to the Board if allowed to testify here. If, upon reviewing this more complete proffer, the Board reconsiders its

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<sup>1</sup> Dr. Chase waited to provide this written proffer in order to obtain a transcript of the prior sworn testimony of the witnesses. Mrs. Chase’s transcript was completed today.

decision regarding Ms. Flanagan and Mrs. Chase, the Respondent requests that he be allowed to present their testimony.

In addition, on January 30, 2007, Respondent intends to introduce Exhibits 650 and 651, which consist of summary charts setting forth certain patient characteristics for the 612 patients on whom Dr. Chase performed cataract surgery in the three and one-half year period between January 2000 and mid-July 2003, and the 818 patients whom Dr. Chase first diagnosed during that same period as having cataracts that he concluded were not visually significant enough to offer cataract surgery.<sup>2</sup> Respondent will also offer testimony that during that same three and one-half year period, Dr. Chase offered cataract surgery to many patients who decided not to have the surgery, and that there were numerous patients who had been diagnosed with cataracts before 2000 and never offered cataract surgery by Dr. Chase.

## **II. Discussion**

### **A. Ellen Flanagan Would Testify Regarding The Standard Informed Consent Procedures In Dr. Chase's Office.**

Ellen Flanagan, R.N., was employed by Dr. Chase as a surgical counselor and nurse in 1998 and 1999. She testified in Dr. Chase's federal trial on November 9, 2005. A certified transcript of her testimony upon direct examination is attached hereto as Exhibit A. If allowed to testify in this case, she would provide substantially the same testimony, including but not limited to the following.

Ms. Flanagan has been a Registered Nurse for 30 years. (Ex. A at 3.) During her career, she has worked with cardiology, cancer, and hospice patients, among others. (*Id.* at 3-6.) She has served as the assistant director of nurses at a nursing home. (*Id.* at 5.) She currently works for

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<sup>2</sup> Respondent will provide the foundation for these charts through the testimony of Kelly Sammel, who compiled them.

the Visiting Nurse Association, where she coordinates the I.V. Clinic.

Ms. Flanagan applied for a nursing position with Dr. Chase's office in 1998. (*Id.* at 10.) She was interviewed by Brianne Chase, who told her that the practice was looking for a "well-experienced, mature nurse." (*Id.* at 9.) Mrs. Chase was not concerned about Ms. Flanagan's lack of prior ophthalmology experience, telling her that "they could teach [her] ophthalmology, but they couldn't teach [her] to be a good nurse." (*Id.*) Ms. Flanagan was hired in September 1998. (*Id.*)

Ms. Flanagan's responsibilities fell into two main categories: (1) circulating in the OR during surgeries; and (2) pre-operative teaching and counseling of candidates for cataract surgery. (*Id.* at 10.) Although there were no legal requirements that the practice employ an R.N. to counsel cataract surgery candidates, Dr. Chase preferred to have someone with "the resources," "the expertise," and the "knowledge base" of an RN in that role. (*Id.* at 12.)

Although Dr. Chase was ultimately responsible for making certain that the informed consent process was complete, Ms. Flanagan understood that "quite often people are overstimulated when they are looking at a surgical experience and things go right over their head when they are sitting and talking with a doctor." (*Id.* at 23.) As a result, she spent between 1.25 and 1.5 hours with each patient, helping them understand their treatment choices and the consequences of those choices. (*Id.* at 32.) Ms. Flanagan began each counseling interview slightly differently, taking her lead from the patient. (*Id.* at 35.) If a patient was upset at the prospect of surgery, she would attempt to put them at ease so that they could absorb the information necessary to making an informed decision. (*Id.*) If a patient appeared comfortable with the prospect of surgery, she might take a more straightforward approach. (*Id.*)

Regardless of the patient's attitude, Ms. Flanagan told each patient that cataract surgery was elective. (*Id.* at 43-44.) She told them that there was "no urgency" to have the surgery. (*Id.* at 43.) The decision to have surgery, she said, "depends [on whether] they were having trouble driving or if they were really having [other] symptoms." (*Id.* at 44.) Ms. Flanagan informed all patients that there were certain advantages to their own natural lenses, (*id.* at 38), and that each patient had to individually weigh the potential of seeing better against the benefits of maintaining those natural lenses. (*Id.*) She discussed the alternatives to cataract surgery with each patient, including the potential benefits, if any, of simply getting new glasses. (*Id.* at 38-39.)

As part of her teaching, Ms. Flanagan reviewed Dr. Chase's informed consent form with each patient, all the while emphasizing that it was the patient's choice to proceed with surgery or not:

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

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

When patients were reluctant to go forward with surgery, Ms. Flanagan would be "very respectful of their reservations," saying, "I want you to feel comfortable with this. I want you to feel safe about this." (*Id.* at 50-51.) If patients asked about getting a second opinion, Ms. Flanagan would tell them: ***"Second opinions are your privilege. They're your prerogative. And they are sound medicine. . . . We're all professionals here and there's no personal---***

*there's nothing personal about this. If you want a second opinion, you should have one.*" (*Id.* at 52.)

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

Ms. Flanagan took extra care explaining the choice of cataract surgery because she understood that Dr. Chase was not always the best communicator. "He tended to talk softly and quickly, and I think people . . . contemplating surgery are so overstimulated that [they] do not always hear everything that's told to [them] anyway, so I found that they'd pick up on some things but not on all things." She attempted to make up for this "shortfall" in Dr. Chase's chairside manner:

[K]nowing that maybe people hadn't heard everything, or felt that their concerns weren't taken into consideration, I would try to make up for that shortfall, you know, and I would ask people, How are you doing? How are you feeling about this? *Because I saw my role as helping people be informed about this procedure, but to feel safe like it was the right thing for them. I wanted them to feel like, that we – that we in general, and I in particular, cared about them as an entire person, not just as a cataract case.* It was important to me that they – that they felt safe, that they felt cared for and that they felt like they could come to us with questions to their full satisfaction.

(*Id.* at 59-60.)

**B. Brianne Chase Will Testify Regarding Dr. Chase's Relevant Office Practices.**

Brianne Chase is Respondent's wife and provided high-level oversight of the non-clinical aspects of Dr. Chase's medical practice. She also hired all of the practice's employees. Mrs. Chase testified at Dr. Chase's federal trial on November 7 and 8, 2005. The transcript of her

testimony upon direct exam is attached hereto as Exhibit B. If allowed to testify in this case, she would provide substantially the same testimony, including but not limited to the following.

Brianne Chase helped Dr. Chase open his first ophthalmology office when the two of them moved back to Vermont after Dr. Chase had completed his residency, his service in the Navy, and his ophthalmology fellowship. She has been periodically employed by the practice, both formally and informally, since then. She testified to many aspects of the non-clinical office practices.

From the practice's earliest days, Dr. Chase strove to adopt new technologies into his practice. In 1974, he was the first ophthalmologist in Vermont to perform cataract surgery through phaco emulsification, a procedure that he learned directly from the physician who invented it at a special course taught in New York City. (Ex. B at 29.) In 1976, he was also the first physician in Vermont to use intraocular lenses ("IOLs") after traveling to San Francisco to learn about the then-new technology. (*Id.* at 31.) He was also among the first physicians in the United States to perform a refractive procedure called radial keratotomy ("RK"), which he traveled to learn directly from the physician who invented it. (*Id.*) Dr. Chase purchased the first excimer eye laser in Vermont, paying \$250,000 for the machine, even though it would never pay for itself. (*Id.* at 32) In the early 1980s, Dr. Chase opened the first and only ophthalmic ambulatory surgery center ("ASC") in Vermont because he was "dedicated to keeping people out of hospitals for as much surgery as you could." (*Id.* at 37.) Although the ASC cost at least \$500,000 to fit up, insurance payment rules did not allow Dr. Chase to charge a so-called "facility fee" for the first 10 years that he used it. During that time, he operated it at his own expense. (*Id.* at 38-39.) While all of these procedures and diagnostic and treatment tools

ultimately became the standard of care for cataract and refractive surgery, Dr. Chase was an innovator in adopting them early in his Vermont practice.

In order to keep abreast of all of the advances in the medical field, Dr. Chase attended an extraordinary number of continuing medical education classes during his three decades in practice. (*Id.* at 51.) In the 16-year period between 1986 and 2003, Dr. Chase accumulated over 3,200 level-one CME credits, even though he was required to receive only 50 per year. (*Id.* at 52.) Dr. Chase also paid for his staff to receive training in ophthalmology, reimbursing their tuition and travel as they attended courses all over the United States. (*Id.* at 53.)

Conscious of the fact that his practice operated the only ASC in Vermont, Dr. Chase sought and received numerous voluntary certifications in order to demonstrate that he offered the highest quality ophthalmic care. For instance, his ASC was certified by AAAHC, a national organization that inspected and recertified the practice every three years. (*Id.* at 54-58.) AAAHC sent nurses and physicians, including ophthalmologists, to review Dr. Chase's patient charts, among other things. (*Id.*) Dr. Chase also set up a quality assurance committee that regularly reviewed and reported on all aspects of the practice, including surgical care. (*Id.*) Dr. Chase invited ophthalmologists and insurers to sit on the committee, which also reviewed his surgical charts on a regular basis. (*Id.*) As the Board has already heard, Dr. Chase was also voluntarily certified by the American College of Eye Surgeons ("ACES"), which reviewed his actual surgeries, as well as 50 consecutive cataract surgery charts, every seven years. (*Id.* at 58-59.)

Brianne Chase was in charge of Dr. Chase's professional and personal finances. (*Id.* at 34, 38.) Dr. Chase had absolutely no interest in money or financial matters generally. (*Id.*) Nonetheless, through the success of his medical practice and Brianne's investment in Burlington-

area real estate, Dr. and Mrs. Chase grew financially comfortable. By the mid-1990s, when Dr. Chase was 60 years old, they were financially secure by any measure. (*Id.* at 74, 94-108.) At that time, Brianne Chase asked her husband to retire, but Dr. Chase loved the practice of medicine too much to quit. (*Id.* at 75.)

Dr. Chase had a very businesslike demeanor when treating patients, focusing intently on their medical care, but little on his own chairside manner. (*Id.* at 60-63.) His singular focus on the patients' health was often misinterpreted by patients and staff alike as being gruff, abrupt, or dismissive of other considerations. (*Id.*) Although Dr. Chase was largely "oblivious" to his limitations as a communicator, Brianne Chase took steps to make certain that his patients nonetheless received empathic, as well as high quality care. For instance, she hired a nurse "whose only job was to educate the patients and communicate with them about the surgery, and deal with all their feelings and everything he wasn't good at." (*Id.* at 67.)

**C. Dr. Chase Intends To Introduce Summary Charts Pursuant To Rule Of Evidence 1006.**

On January 30, 2007, the respondent will offer summary charts showing that in the three year and seven month period between January 1, 2000 and July 21, 2003, Dr. Chase performed cataract surgery on 612 patients and diagnosed another 818 patients to whom he did not offer surgery because he concluded that their cataracts were not visually significant enough to warrant surgery. Copies of these summary charts, previously provided to the State and marked as Exhibits 650 and 651, are attached hereto as Exhibit C. Many of the 612 patients who had cataract surgery during this period were first diagnosed with cataracts before 2000 and, in fact, the average time elapsed between diagnosis and surgery for these 612 patients was three and one-half years. The 818 patients contained on Exhibit 651, none of whom were offered surgery, were all diagnosed with cataracts sometime after January 1, 2000.

Many, but an undetermined number of other patients were diagnosed with cataracts before January 1, 2000, and were never offered cataract surgery by Chase. Approximately 238 patients were offered cataract surgery, but declined to have it, after January 2000.

**D. All Of Dr. Chase's Proffered Evidence Is Relevant And Admissible.**

The proffered testimony of Ellen Flanagan and Brianne Chase, as well as Dr. Chase's summary charts, are all highly relevant and admissible and should be allowed into evidence.

The testimony of Ellen Flanagan directly rebuts the claims of many of the complaining patients that Dr. Chase was coercing them into unnecessary cataract surgery. It also contradicts one of the main themes of the State's case – that Dr. Chase and his practice told patients that they “needed” cataract surgery regardless of the severity of their symptoms. To the contrary, Ms. Flanagan's testimony demonstrates that every patient was explicitly told that cataract surgery is elective and that they should not choose surgery unless their vision bothered them enough to assume the risks inherent in the operation. She also told patients that second opinions were their privilege, and that they should get a second opinion if they wanted one. Moreover, the very fact that Dr. Chase employed Ellen Flanagan, and other empathetic nurses like her, to administer the full informed consent presentation, strongly rebuts the State's claim that Dr. Chase was bent on performing surgery that his patients did not need, regardless of their alleged lack of serious symptoms. The State's unsupported arguments to the contrary, evidence of motive is always relevant. *See, e.g.* Wigmore on Evidence, vol. 1, § 118 (Supp. 2001); *see also United States v. Chas. Pfizer & Co.* 281 F. Supp. 837, 848 (S.D.N.Y. 1968); *People v. Wallace*, 217 N.Y.S. 244 (1926) (because motive shows “the probability of appropriate ensuing action, it is always relevant”).

The fact that Ms. Flanagan did not provide the informed consent presentation to any of the 11 complaining patients is beside the point. She worked for Dr. Chase during the very center of the time period covered by the State's allegations. She testified that she was trained by a 20-year employee of the practice and that she trained the nurses who came after her. She also confirmed that each and every patient who was considering cataract surgery received the full informed consent presentation. In short, if allowed to testify, she would present evidence that it was the habit of Dr. Chase's office to give every potential cataract surgery patient, including the 11 complaining patients, an exhaustive education regarding the surgery and to present the operation as an elective procedure that they should have only if their vision was not meeting their needs. She will also demonstrate that it was the practice's habit to encourage second opinions whenever the patients asked.

As such, Ms. Flanagan's proffered testimony is admissible to prove that Dr. Chase and his staff treated the 11 complaining patients in conformance with the habitual process she described. Vermont Rule of Evidence 406 states, "Evidence of the habit or the routine practice of a person or organization . . . is relevant to prove that the conduct of the person or organization on a particular occasion was in conformity with the habit or routine practice." V.R.E. 406. Under this rule, Ms. Flanagan's testimony is clearly admissible to show how Dr. Chase's practice treated, or would have treated, the 11 complaining patients, even though Ms. Flanagan did not personally counsel them.

Brianne Chase's testimony is relevant and admissible for similar reasons. First, her testimony regarding Dr. Chase's innovative approach to practicing ophthalmology, and his desire to continuously learn and incorporate new diagnostic and treatment methods, helps to explain his early adoption of CST and BAT testing, which is at the center of this case. The State has asked

the Board to conclude that Dr. Chase used these diagnostic tests for the purpose of justifying unnecessary surgery. Brianne Chase's testimony shows that his use of these tests was part of a long practice of providing his patients with the most innovative eye care available, regardless of whether other local doctors adopted his testing and treatment methods.

The State has alleged that Dr. Chase's charting methods were an attempt to mislead others into believing his patients needed cataract surgery when in fact they did not. Brianne Chase's proffered testimony regarding Dr. Chase's numerous voluntary certifications shows that he regularly invited scrutiny of his surgical and charting practices, going so far as to invite other physicians and insurers to review his cataract surgery charts. She will testify that he did all of this in order to improve the quality of the care he provided to his surgical patients---the central topic of this disciplinary hearing. At the very least, Dr. Chase's habit of inviting others to scrutinize his practice strongly rebuts the State's argument that he was purposefully shielding his surgical decisions from scrutiny through his charting practices.

Mrs. Chase will also testify that Dr. Chase had no profit motive to perform unnecessary cataract surgeries, as the State implicitly suggests. First, such a motive would be inconsistent with his habit of putting patient care ahead of profit. He demonstrated this habit over and over again as he incorporated expensive new treatments and tests into his practice without the promise or hope of compensation. It would also be inconsistent with his financial means: Dr. and Brianne Chase were financially secure and did not need or desire additional income. Indeed, Brianne Chase would testify that they disclaimed \$1,750,000 in inheritance during the very period covered by the State's charges because they did not need the money. (Ex. B at 107-08.)

Like Ms. Flanagan, Brianne Chase's testimony would also help rebut the complaining patients' testimony that Dr. Chase treated them dismissively in order to railroad them into

cataract surgery. As Mrs. Chase and Ms. Flanagan testified, Dr. Chase's chairside manner was often misinterpreted by his patients to evidence a lack of concern for their needs. However, Dr. Chase's demeanor was not indicative of a lack of concern; rather, it was the product of his singular focus on finding and fixing his patients' vision problems. Moreover, his medical practice worked hard to compensate for Dr. Chase's shortcomings as a communicator. For all of these reasons as well, Brianne Chase's proffered testimony is relevant to Dr. Chase's treatment and interactions with each of the eleven complaining patients. V.R.E. 406.

Finally, Dr. Chase's proffered summary charts are admissible because they place in context the isolated nature of the 11 patients handpicked by the State to serve as the vehicle for its charges of unprofessional conduct. These charts utterly belie allegations in the State's Specification of Charges that Dr. Chase knowingly falsified the records of these patients and dishonestly urged them to have surgery he knew they did not need. Why would he dishonestly urge surgery for these patients (most of whom had been diagnosed with cataracts years before) while at the same time diagnosing cataracts, but not recommending surgery, for another 818 patients (a number that does not include many others who were diagnosed before 2000 and never offered surgery)? In addition, the fact that 238 patients declined cataract surgery that was offered after 2000 underscores the effectiveness of the Chase practice's informed consent procedure in providing the patients complete discretion to decline offered surgery. All of these statistics are relevant and admissible to contradict the State's charges of purposeful bad behavior by Dr. Chase and to provide vital factual context to the 11 hand-picked complaining patients' claims.

### III. Conclusion

For the foregoing reasons, the Board should reconsider its decision to exclude the testimony of Ellen Flanagan and Brianne Chase in light of this proffer and should allow the admission of Dr. Chase's summary charts.

Dated at Burlington, Vermont, this 24<sup>th</sup> day of January, 2007.

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