July 23, 2022

Optometry Technical Review Committee

To whom it may concern:

I am a practicing board-certified ophthalmologist who serves a primarily rural population. As with my ophthalmology colleagues, I oppose the expansion of optometric privileges to include SLT. Not expanding this scope of practice will not cause harm to patients, while the potential benefits of expanding this practice do not outweigh the potential risks. I have significant respect for the optometrists I interact with and have always had an excellent working relationship with them. However, optometric education is not equal to that of ophthalmology. While we are fortunate to have a relatively safe procedure available in SLT, it is still an advanced procedure and an intraocular surgery. As with many surgeries, more important than the technical skills is the knowledge, judgment, and experience in assessing the appropriateness, risks, etc. that goes into decision-making.

These technical skills, knowledge, and judgment take extensive training. Evaluation of the angle via gonioscopy which is critical to identify structures for SLT often is not straight forward. It takes significant time to become proficient and requires having a more experienced physician available to assess and affirm/educate on findings with many patients. A weekend course is not adequate. Ophthalmology residency begins after four years of medical school and one year of internship. In ophthalmology residency, we spend most of our time on the nuances of diagnosis and treatment of routine and complex ocular and systemic disease in contrast to optometry which has a stronger focus on glasses and contact lenses. We are trained in a tertiary care university setting rotating through all subspecialities in ophthalmology where we see typically the most complex ocular diseases with fellowship-trained subspecialists. We learn when a patient needs to be referred to a subspecialist. We spend four MONTHS on the glaucoma service during our first two years and then continue with continuity of care with our own patients during our third year. We perform gonioscopy on multiple patients a day under the supervision of glaucoma specialists. In addition, there is significant focus on the diagnosis and treatment of the many forms of primary and secondary glaucomas, both open and closed angle. This skill set is critical to assessing the appropriateness of SLT versus other treatment. SLT is not a cure for glaucoma and not all glaucoma is amenable to SLT. Postponing surgical intervention for repeated SLT because it is "convenient" puts patients at risk of permanent vision loss.

For instance, in a patient who I am assessing for SLT who has a cataract, I am also considering whether the angle is becoming narrow, which is less likely to benefit from SLT and may benefit from cataract surgery instead or whether cataract surgery plus glaucoma surgery may be needed. How likely SLT is to work on a particular patient is based on their angle structure, intraocular pressure, and disease severity. There are many nuances to consider.

With respect to safety and best interest of the patient, many factors play a role. SLT is an intraocular surgery. Intraocular procedures have higher inherent risks. Most patients do not understand the

difference between optometrists and ophthalmologists. They assume they have the same training and just know they are all “eye doctors.” It is our duty to protect patients and do what is best for them within the scope of our training and expertise.

Proper treatment requires proper diagnosis. In our office, it is not uncommon to have patients referred by their optometrist for cataract evaluation who have undiagnosed glaucoma or other retina issues as the source of their vision loss. Last week, a patient was referred for a large hemorrhage in his retina causing significant vision loss. He did not have a hemorrhage, but rather a stroke in his eye called a central retinal artery occlusion with intraarterial plaques, requiring referral to the ER for a stroke workup.

Other diagnostic problems with glaucoma include misdiagnosis, underdiagnosis, and overdiagnosis. Patients can have other diseases that can mimic glaucoma, such as a tumor behind the eye pressing on the optic nerve. SLT in the wrong setting can delay diagnosis or falsely give reassurance of adequate treatment to patients with advanced glaucoma. We have also seen patients diagnosed and treated long-term for glaucoma with medications, who have no evidence of glaucoma nor history of ocular hypertension. These patients could unnecessarily be subjected to an intraocular laser. As previously mentioned, SLT is not a cure for glaucoma and is not risk-free. Patients continue to need monitoring and often continue to need drops and may still require other surgical intervention.

With respect to the inconvenience of travel to receive an SLT or other procedure, I can attest after 15 years in practice that patients and their families are not opposed to travel if it is in the patient’s best interest. SLT is certainly not the only treatment patients need to travel for, but as it is elective and non-emergent, it can be arranged at the patient’s/family member’s convenience and requires a single trip. This is in contrast to emergent laser for a retinal tear or acute angle closure, new exudative macular degeneration requiring timely intravitreal injection, lasers for proliferative diabetic retinopathy or many of the other referrals we receive for a multitude of urgent vision-threatening issues, all of which require inconvenient travel and often multiple trips. Even with cataract surgery, if the cataract is quite advanced, I will schedule surgery in Scottsbluff rather than at a satellite hospital as I have determined it to be in the best interest of the patient .

Even as ophthalmologists, we will refer patients to other subspecialists within ophthalmology, such as glaucoma, neuro-ophthalmology, or oculoplastics. While it may not be “convenient”, patients are very appreciative to be sent to the specialist most able to help them. This may be to Denver or Omaha. I have a patient in Ainsworth who travels every six months to the nation’s top ocular oncologist in Philadelphia. He is grateful to be under her care and I monitor him in between.

I have not been aware of a backlog of patients needing SLT and not getting it. This has never been brought to my attention by any of the optometrists we have worked with. If access is an issue, topical drops continue to be an option and continue to be effective. In fact, many patients opt for drops when given a choice between SLT and drops. If the Nebraska Optometric Association is highly concerned about patients getting SLT, another option is to have hospitals we work at purchase an SLT. Given that we travel to each hospital two to three times per month, this would provide SLT rendered by an ophthalmologist. Both Valentine hospital and Ogallala hospitals have purchased a different type of laser used to open a cloudy membrane after cataract surgery.

Our ophthalmologists currently serve the Panhandle in western Nebraska via our main office in Scottsbluff and through satellite clinics held at rural community hospitals in Ainsworth, Valentine, Ogallala, and Grant two to three times per month. We previously also provided clinic and surgery in Sidney, Kimball, and Alliance; however, lower patient numbers over the years required us to discontinue those clinics. Most of those patients now travel to Scottsbluff. Both of our board-certified ophthalmologists perform SLT as well as other glaucoma procedures in our Scottsbluff office.

Additionally, some ophthalmologists rely on optometrist referrals, so they are often reluctant to speak for fear of retaliation in the form of decreased referrals. But our role is to be an advocate for patient safety and best practices. As previously mentioned, not expanding this scope of practice will not cause harm to patients, while the potential benefits of expanding this practice do not outweigh the risks.

Thank you for your time.

Sincerely,

Shawna Collier, MD
Scottsbluff, Nebraska