

'Once I was blind, but now I can see...'

The title is taken from a hymn that describes spiritual healing — appropriate in this account. However, the legally blind recipient received much more than he asked for: sudden restoration of irreversibly-lost central vision. This document^a describes and analyzes the account¹ extensively.

Legally blind

After several years of difficult police work, Greg Spencer changed occupations and drove cross-country trucks. But he soon had to stop after loss of central vision severely limited sight in both eyes and ultimately rendered him legally blind. He ended up getting help from the Oregon Commission for the Blind and qualified for disability payments.

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Legally blind

A letter and test data from Oregon Health and Science University ophthalmologist Dr. Richard Weleber (an expert in retinal disorders) and a letter from optometrist Dr. John Boyer document the evaluation and diagnosis of Greg's legally blind condition and present recommendations for state assistance. See [Figure 1](#) through [Figure 6](#).

NOTE 1) I analyzed much of the evidence in substantial detail — especially the Dr. Weleber letter and data, explaining meanings and significance as appropriate. To help me in that task, I enlisted the paid help of an online retina specialist. See [Appendix A: Greg Spencer evidence analysis](#).

2) To maximize readability of the limited-legibility evidence scans displayed in this account, I've graphically widened and occasionally lengthened some text to maximally fit the small document page. Therefore, the font appearances of the multi-page Dr. Weleber letter are slightly inconsistent.

'Once I was blind, but now I can see...'

Legally blind

Figure 1 Dr. Weleber diagnosis, page 1 of 3

May 31, 1999

Portland, OR

SURGEONS

Bradley H. Seely, M.D.
[REDACTED] Blvd.
Suite [REDACTED]
[REDACTED], OR [REDACTED]

54
E
DY
M.D.
ID

SERVICE
S.A.
F.A.L.S.A.

Re: Gregory Spencer
DOB: 07-03-1958

DISEASE
M.D.
F.P.C.
M.D.
S.M.D.
M.D.

Dear Brad:

ULTRASOUND
S.R., M.D.

On May 21, 1999, I saw Greg Spencer, the 40-year-old gentleman who you referred for evaluation because of his failing central visual acuity. He is the only one in his family so affected. At about age 12-13, he began to experience reduction of vision and his parents were told that he had swelling of the retina. Apparently the vision improved in about 10 months and eventually came back to the 20/30 to 20/40 level, which he maintained for many decades. From age 30 to age 39, he was a police officer. He recently has gone through a professional driving school for driving both trucks and heavy machinery equipment. However, because of difficulty with his central acuity, this began to become very difficult for him over the past several months. His visual acuity was still 20/40 in August of 1998, but in April of this year the visual acuity had dropped to the 20/60 level and he stopped driving entirely.

M.D.
M.D.

WICE
M.D., Ph.D.
M.D.

OLNMOLOGY
M.D., Ph.D.

ATHOLOGY
M.D.

LASTIC AND
E SURGERY
M.D., Ph.D.

M.D.

THOLOGY
S.C., Ph.D., M.D.

Without correction his visual acuity today was CF at two feet, 20/400 letters at near in the right eye, and 20/200 no improvement with pinhole at distance, 20/200 letters at near, left eye. The near acuities were with a +2.00 sphere reader in each eye. Tonopen intraocular pressures were 15 mm Hg OU. We were unable to improve the vision with manifest techniques. Goldmann perimetry visual fields performed the previous day disclosed dense central scotomas in each eye, with the larger more dense scotoma being present in the right eye. Ocular motility, external

WOM M.D.
M.D.

TREOUS
JRGERY
M.D.
S.R., M.D.

M.D., Ph.D.
M.D.

OPHIES

'Once I was blind, but now I can see...'

Legally blind

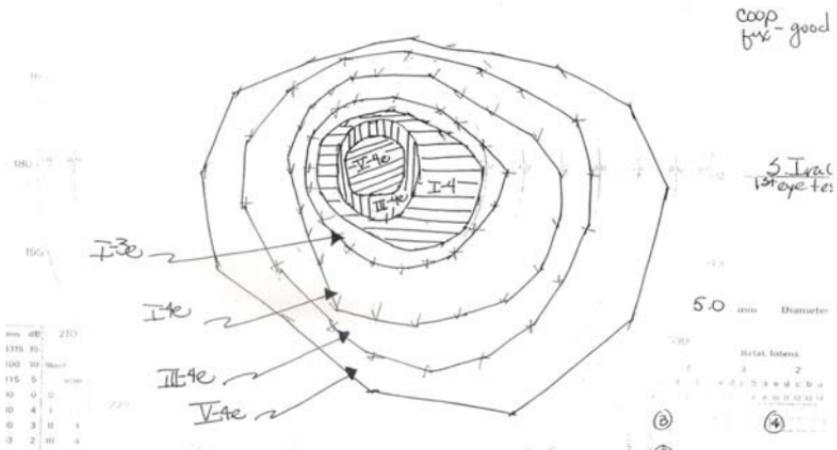
Greg's 20/400 vision indicated that he effectively needed to be positioned 20 feet from an eye chart to read letters that a normal-eyesight person (20/20 vision) can read at 400 feet; his 20/200 vision indicated that he needed to be within 20 feet to read letters that a normal-eyesight person can read at 200 feet.

[Figure 2](#) and [Figure 3](#) below present the Goldmann perimetry results for Greg — which show how well the various areas of Greg's retinas detected light. (I explain Goldmann perimetry in [Appendix A: Greg Spencer evidence analysis](#); see [Dr. Weleber letter — page 1, paragraph 2, sentence 5.](#)) Note that the shaded areas in [Figure 2](#) and [Figure 3](#) indicate central 'scotomas' — areas of central vision loss in the macular area of Greg's retina. The macular area of an eye, especially the fovea, accounts for the great majority of vision under normal (relatively bright) lighting conditions.

'Once I was blind, but now I can see...'

Legally blind

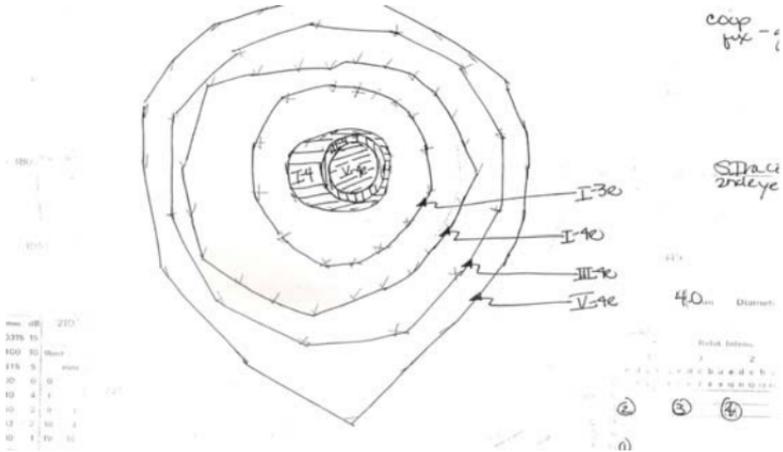
Figure 2 Dr. Weleber Goldmann perimetry, right eye



'Once I was blind, but now I can see...'

Legally blind

Figure 3 Dr. Weleber Goldmann perimetry, left eye



'Once I was blind, but now I can see...'

Legally blind

Figure 4 Dr. Weleber diagnosis, page 2 of 3

examination, and biomicroscopy were normal. On fundus examination, the optic nerve heads were pink with 0.3 cup-to-disc ratio, and the retina vessels, peripheral choroid, and peripheral retina all unremarkable and normal in appearance. The foveal region had rather striking retinal pigment epithelial mottling bilaterally in an oval distribution of about one disc diameter in size, greater for the right eye than for the left eye. Also on May 20, 1999, Greg had an electroretinogram which disclosed normal amplitudes and implicit times for both rod and cone mediated responses. The final 45-minute rod psychophysical threshold was mildly elevated above normal in each eye.

All things considered, Greg appears to have a macular degenerative process in each eye that has finally resulted in legal blindness status for his better seeing left eye. Because of the rather sudden fall in acuity the most likely situation was that he had a tight ring scotopic around fixation with a central island of vision for the left eye that finally got "snuffed out" leaving him with the large central scotoma. The central scotomas on Goldmann perimetry appear larger than one would expect from just the fundus appearance alone. Nevertheless, I believe that the scotoma sizes are correct and his maculopathy is cause for his marked reduction of acuity.

I spent considerable time discussing with Greg the findings, his current legal blindness status, the lack of any known treatment or surgical benefits, and the various support services available through the Oregon Commission for the Blind. We also gave him literature for the Foundation Fighting Blindness and had our social worker, [REDACTED], meet with him for discussion of support groups and how to proceed with his life. The news of his visual acuity reaching the legal blindness status was quite a shock for Greg and he will need considerable support to assist him through the process of achieving disability and possibly some vocational rehabilitation since all of his work in the past twenty years

'Once I was blind, but now I can see...'

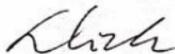
Figure 5 Dr. Weleber diagnosis, page 3 of 3

has been related to driving, which will no longer be possible for him.

Finally, I discussed the high likelihood that this is a genetic form of macular degeneration. This could be either an autosomal recessive trait or less likely, an incompletely penetrant dominant trait inherited through one of this parents, or, least likely, a new dominant trait with Greg being the first in his family to be affected. The latter scenario, I believe, is not likely but that is the inheritance situation that would result in the greatest risk for his children to possibly inherit and develop the condition. At this time, I recommend only routine eye care for his children.

Thanks for asking me to see this gentleman in consultation. Please let me know if I can be of any further assistance. I recommended that he be re-evaluated in another year.

Sincerely yours,



Richard G. Weleber, M.D.

RGW:bcw

Enc.: Copy of Goldmann perimetry visual fields
and ERG report

Note that Greg's severe central vision loss was diagnosed as macular degeneration — an ***irreversible***

'Once I was blind, but now I can see...'

Legally blind

condition. He was given aid from the Oregon Commission for the Blind, a state agency, where he received training to live as a legally blind man (albeit with some remaining *peripheral* vision). See [Figure 6](#) below. He anticipated being on disability for the rest of his life.

'Once I was blind, but now I can see...'

Legally blind

Figure 6 Dr. Boyer request to Commission for Blind

June 23, 1999

COMMISSION F/T BLIND

Portland, Oregon

██████████, MS, Director
Oregon Commission for the Blind
fax # (503) 731-██████████

JUL 1 1999

Re: Greg Spencer, CEI # 01-██████████

Dear ██████████:

Today I evaluated Greg Spencer at the request of ██████████. You are aware of his medical condition (macular degeneration) through the report by Dr. Richard Weleber. On June 24, Greg will be at your office to meet your staff and tour the facility. I am of the impression he will soon be going through your complete orientation and vocational assessment and training, including O&M.

Entering vision without correction at distance was: OD 20/500-, OS 20/300. Refraction found low hyperopia of +.75 sphere for each eye. Acutities with correction were unchanged. I could not test his accommodation directly, but I assume because he is 40 years old that some element of presbyopia exists for prolonged close work such as computer use. I am recommending a spectacle prescription for eventual computer use of: OD +3.75 sph., OS +3.75 sph.

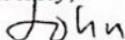
I demonstrated the ZoomText Extra software program to him briefly. You may want to expand upon that. He is a budding author and is struggling with his old computer system and a handheld small diameter +6.50 magnifier. In his new line of employment, he will clearly need software similar to ZoomText. I also told him there is a place for portable magnifiers and that ██████████, or I, will need to look at that issue on a separate occasion, and in regard to specific identified visual tasks.

He is in need of fulltime protection of his preferred left eye and some assistance for his significant photosensitivity, which seems to be concurrent with his macular vision loss. To address these issues, I am recommending a polarized Grade "A" filter (mild tinting effect but full polarization benefit) in today's refraction of +.75 sphere for each eye. These should be worn during all waking hours and are intended for indoor comfort without causing a darkening of vision. When outdoors, or in intense lighting conditions or near water caused reflections, I want him to also use a fit-over dark polarized filter such as the Eschenbach D-244A.

If you wish, I can mail the two spectacle prescriptions to your office. I was not given instructions on how you wish to proceed with recommendations from this evaluation.

Thank you and thanks to ██████████ for asking me to see this pleasant fellow.

Sincerely,



John M. Boyer, OD

cc: ██████████, LCSW

'Once I was blind, but now I can see...'

Healed

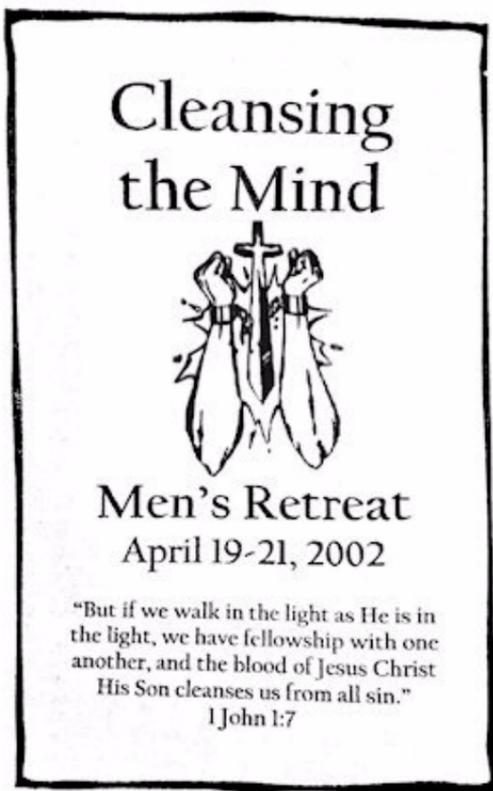
NOTE Note in the second paragraph of [Figure 6](#) that Greg's visual acuity had deteriorated even further by the time of the Dr. Boyer visit. In this letter to the Oregon Commission for the Blind, Dr. Boyer recommends a variety of assistance for Greg.

Healed

During his time of legal blindness he met and ultimately married Wendy — a committed Christ-follower who introduced Greg to Christ as well. Then, in April of 2002, Greg attended a spiritual men's retreat called *Cleansing the Mind*. See the retreat-brochure's cover image, [Figure 7](#) below, the evidential relevance of which will ultimately become apparent.

'Once I was blind, but now I can see...'

Figure 7 'Cleansing the Mind' brochure-cover image



Regarding the focus of this retreat on "Cleansing the Mind", Greg notes that:

"I recognized I needed that."

'Once I was blind, but now I can see...'

Healed

Why? His prior years of police work had exposed him to so much violence, death, and depravity, and so many mutilated bodies (as a deputy medical examiner) and pornographic images, that he'd left the profession a hardened and emotionally scarred man — a condition that had cost him his first marriage. Despite having left law enforcement, the awful scenes he'd witnessed remained in his psyche:

“I couldn't sleep nights; the horrid graphic nightmares that I would constantly have closing my eyes with these visions of the violence, the pornography, the bodies, were just overwhelming. I'd wake up screaming at night with these nightmares.”

At the retreat, Greg appealed to God for release...

“My prayer...was, ‘Lord, cleanse my mind, take this junk away, set me free!’”

But he received more than he'd asked for...

“Shortly after praying that I felt the Lord telling me ‘You're clean.’ I opened my eyes and, lo and behold, at the back of the stage where I sat in this chapel I could see a tiny sign that said red ‘Exit’

‘Once I was blind, but now I can see...’

Observational confirmation

and at that point realized I had been cleansed of my sin, but I'd also been healed, and my vision had been totally restored."

Observational confirmation

The preceding subsection is necessarily brief. Greg, described to me as very shy, declined to elaborate further on his healing experience. Therefore, to flesh in the events, I phoned two other people who were present at the *Cleansing the Mind* retreat. First I talked with Travis Hunt, who led the session during which Greg dramatically regained normal visual acuity. I later talked with Randy Webb, another pastor at the retreat. Both, it turned out, observed irrepressible excitement by Greg about his renewed vision and observed his 'environmental testing' thereof. Context and key observations follow (not including some further-confirming information that, unfortunately, I must omit to protect Greg's privacy).

'Once I was blind, but now I can see...'

Background comments

Before I highlight some of Travis's and Randy's observations, here's a bit of background information:

- The weekend retreat was held at a rustic campground that included a simple wood-paneled chapel.
- Prior to Greg's dramatic visual restoration, Travis knew him only "roughly." (Randy knew him better, having officiated at Greg's marriage to his present wife.) Travis knew only "that he had bad eyesight" without any idea of the severity of the impairment. Travis had noticed earlier in the session — prior to the healing — that...

"He tried to read. I saw him with multiple pairs of glasses on at once... And he was turning his head sideways, seeing if he could magnify the Word large enough so he can get it through his peripheral vision. He was capable of doing that. I caught him doing that once.

But I had no idea. I didn't know any of his story."

- Using his remaining peripheral vision — a notably poor substitute for central vision in good lighting

'Once I was blind, but now I can see...'

Observational confirmation

conditions — Greg could make his way around *before* the healing in a limited way without assistance. The figures below, attributed to the NIH National Eye Institute and widely displayed on the Internet² (including at some professional sites), contrast normal vision, left, with the effects of age-related macular degeneration, right.



The figures above are of course illustrative and not precisely indicative of Greg's specific condition — which, per my analysis ([Appendix A: Greg Spencer evidence analysis](#)), was apparently more severe. They nonetheless illustrate a need for people with macular degeneration to rely on peripheral vision and the possibility of unaided, albeit impaired, navigation on foot.

'Once I was blind, but now I can see...'

Context and observations

Travis noted that he'd solidly prepared to *teach* about 'cleansing the mind' in this session but then had inwardly sensed God urging him *not to teach* that day. So, following that leading, he simply had an accompanist repeatedly play the tune to Keith Green's *Rushing Wind* song, had the group sing the lyrics he'd remembered (albeit somewhat incorrectly), and use it as a prayer. The song's lyrics,³ a few of which I quote below, speak of spiritual cleansing and renewal:

"Rushing wind blow through this temple [referring to God's place within a Christ-follower],

Blowing out the dust within,

...

Holy spirit, I surrender, take me where you want to go."

So, Travis noted,

"We took off our shoes and knelt down, and I said, 'Here's, what we're going to do. We're going to sing this song, repeating this song until we've

'Once I was blind, but now I can see...'

Observational confirmation

actually meant it...actually prayed the song. And I want you to ask God to cleanse your mind.”

Travis asked the attendees to stand if — and only if — God had told them inwardly that he'd cleansed them.

“I had no plans. That was it...we were singing, and Greg was two rows back on my left [Travis was in front, on the stage of the chapel in which the session was held]. I'm sitting there and we're praying. [Accompanist] Mark is playing the music on stage, and I'm praying and leading in singing.

And I see Greg, whom I just knew roughly...stand up. I'm thinking 'Praise the Lord! Praise the Lord! God spoke to him'...and it looks like he's trying to hold back big blinking. You know, [like] when people really struggle not to cry. [NOTE: Travis found out later that when Greg was blinking he'd been staring at the *knots* in the chapel's wood-paneled ceiling with his new-found vision!] And I thought, 'Oh man, God's really working on his heart; there's something really going on in his heart....This guy needs to pray with somebody; he's obviously got some sort of sin that he's dealing with, and he's just wrestling with God over

'Once I was blind, but now I can see...'

Observational confirmation

this sin.' And that wasn't *at all* what was going on. And I said,

'Well, hey, you should pray with a pastor right now and just make a confession and get right with God. There's some pastors and elders in the back of the chapel. Just go see them.'

He ran! He jumped out and ran. He was the only one in his pew. And he ran!

Now I didn't know about his eyesight at this point. I knew he had bad eyesight, but I didn't know how severe it was and was shocked that he ran out. Instead I thought 'Man, that guy really has issues!'"

Greg ran to the chapel door where Randy was standing nearby at the time. Randy related what happened next:

"...he [Greg] said,

'Randy I've been healed!'

I said, 'What?' He goes,

'I can see. I can see!'

And I said, 'Really?' 'Well, look out here.' The grass was really flush green..., and it was about

'Once I was blind, but now I can see...'

Observational confirmation

three or four inches tall. And, there were these little tiny black birds jumping through the grass off in the distance, and you could barely see the tops of their heads. And I said, 'Can you see those birds out there?' (They were hard for me to see, and I've got good vision!) And he goes,

'Yeah! I can see those birds!'

And he was pointing them out. But see, that's why he ran to the back...to look outside. [Randy noted that the chapel's lighting had been a bit dim.] Because he was all of a sudden blown away that he could see."

Moreover, Randy noted,

"He was looking up into the branches of trees and telling me what he could see... he could see these little birds. And just looking all over the place, taking it all in, you know."

Randy subsequently walked up the aisle to Travis and whispered the news of healed blindness. But Travis related to me that he initially didn't comprehend what Randy was communicating:

"I said, 'Well, ya know, that's great.'...I'm thinking somebody had a deep change. I think it's a meta-

'Once I was blind, but now I can see...'

Observational confirmation

phor. And he [Randy] goes, 'No. A blind person just received their eyesight.'

Randy further noted the following, which Travis said he observed as well:

"We [including Travis] walked out in the parking lot, you know after he [Greg] looked at the branches and stuff... And he was standing there reading [aloud] license plates on the other end of the parking lot... That was at least 150 to 200 feet away. I mean it was all the way across to the other side of the campground, basically."

Randy noted that the license plates were hard to read even for him and Travis.

Moreover, Greg didn't quickly stop marveling in his newfound vision. Per Randy,

"And, matter of fact, it was going on all weekend, it was going on all the way home..."

Greg still saying...

"I can see that. I can see that."

'Once I was blind, but now I can see...'

Medical confirmation

Following this experience, Greg realized he now needed to get off disability. Notifying the government that he could now see and was no longer disabled triggered a year-long investigation. The conclusion, “...*after numerous medical exams...*” <Greg's statement, emphasis mine> was that a remarkable healing had occurred. Ophthalmologist Dr. Jon Burpee's letter, [Figure 8](#) below (written just a few days after the retreat dates), provided key evidence.

'Once I was blind, but now I can see...'

Medical confirmation

Figure 8 Dr. Burpee letter verifying remarkable vision change



**Umpqua Valley
Eye Associates**
www.uvea.eyemd.org

*Jon C. Burpee
Eye Physician*

May 3, 2002

Mr. Gregory Spencer

██████████ Street, ██████████

██████████, OR ██████████

To Whom It May Concern:

Dr. Bradley Seely saw GREGORY SPENCER in March of 1999 with a best-corrected visual acuity of 20/200 in the right eye and 20/70 in the left eye. Examination revealed a loss of macular reflex bilaterally, and the patient was referred to Dr. Richard Weleber at the medical school. His examination found that he had 20/400 vision in the right eye and 20/200 vision in the left eye. Hereditary macular degeneration was diagnosed. It is noted at this time that the patient had an episode as a youngster, when he was in his early teens, where he lost visual acuity and then recouped it, until about age 38.

The patient was seen on the 3rd of May 2002 with a remarkable return of his visual acuity. The vision is measured, without correction, at 20/30 in each eye. Examination shows mild macular pigment scatter but no macular edema or deposits at this time. Hopefully his visual return from the 20/200 level in each eye will be permanent.

Sincerely,

Jon C. Burpee, M.D.

JCB/swb

'Once I was blind, but now I can see...'

Medical confirmation

On June 12, 2003, the Social Security Administration finalized the process of discontinuing Greg's disability payments, with the following letter ([Figure 9](#) on the next page):

'Once I was blind, but now I can see...'

Medical confirmation

Figure 9 SS Administration fraud-investigation satisfaction that remarkable vision change occurred

Social Security Administration Retirement, Survivors and Disability Insurance Notice of Disability Cessation

Gregory Lee Spencer

██████████ St

██████████, OR ██████████

Telephone:

Date:

JUN 12 2003

Claim Number(s): ██████████-67

We're writing to let you know that we've made a decision on your case. After reviewing all of the information carefully, we've decided that your health has improved since we last reviewed your case and you're now able to work. This means that your benefits will stop.

When Your Checks Will Stop

You're no longer disabled as of 06/03. You'll get checks for that month and the next two months. Your last check will be for 06/03.

When Your Medicare Will End

If you have Medicare, your coverage will end the last day of 08/03.

The Decision on Your Case

The following medical evidence was used in evaluating your original claim:
Oregon Health Sciences University records received from 1999
Bradley Seeley, M.D. records received 6/24/1999
Richard Weber, M.D. records received 6/24/1999

At the time you were awarded benefits, you were found to be disabled and unable to work due to macular degeneration causing statutory blindness.

The following reports were used in making this decision:
John Burpee, M.D. records received 5/1/2003
Oregon Commission for the Blind records received 4/29/2003

Your file has been returned to us at this time to determine if there has been any change in your condition.

You have stated that your vision has been restored. Testing performed on May 3, 2002 indicated that there had been a remarkable return of your vision. There are no limitations placed on your ability to perform work activity at this time. Therefore, your benefits will stop

'Once I was blind, but now I can see...'

Truly a miracle?

Based on the independent observations of Greg's restored sight at the time he specified and my detailed analysis of the evidence (see [Appendix A: Greg Spencer evidence analysis](#)), I *unequivocally* conclude the ***affirmative***.

- Greg's severe central vision ***loss*** was an ***irreversible*** condition that could ***not*** have gone away naturally:
 - Greg had foveal epithelial mottling in both eyes — a condition that my retinal consultant says “***never goes away.***” <Emphasis is mine.> Though foveal epithelial mottling may have multiple causes, it's ***always*** a sign of compromised central vision.
 - Carefully done Goldmann perimetry tests for Greg show large central-vision ‘scotomas’ — areas of vision loss. Though these tests may not have fully quantified the ***degree*** of severe central vision loss, they clearly demonstrated the ***fact*** of severe central vision loss.
 - The results of Dr. Weleber's electroretinogram tests are consistent with central vision loss.

'Once I was blind, but now I can see...'

Truly a miracle?

- Greg was diagnosed with macular degeneration, generally recognized to be an **irreversible** condition.
- As a result of multiple examinations, Greg was medically declared legally blind and was provided substantial government help for that condition.
- Greg's central-vision **RESTORATION** could not have been faked.
 - Good vision — like any ability — *cannot* be faked, neither in acuity tests nor in normal-life *functionality*. People cannot demonstrate functionalities they don't possess.
 - Examination of Greg's inner eye after restoration of his acuity apparently showed the absence of any significant pathology.
 - The government launched a one-year investigation of possible disability fraud and ended up satisfied that Greg had indeed experienced a “remarkable” return of vision.
- Greg's middle-age vision loss and restoration was **not** an encore performance of his youthful vision loss and gradual, natural restoration (page 1 of

'Once I was blind, but now I can see...'

Truly a miracle?

Dr. Weleber letter, sentences 3 and 4). Key distinctions of his middle-age loss and restoration:

- Different pathology.
- Uncorrectability by any known means.
- Established **irreversibility**.
- Legal blindness status.
- Extreme *rapidity* of vision restoration (vs. restoration over a period of ten months in his youth). Beyond the anecdotal *claim* of rapidly restored vision by Greg — a person who demonstrated his honesty by voluntarily ending his disability payments — the following points argue for extremely rapid restoration:
 - The a of retreat participants who observed Greg's irrepressible excitement about his renewed vision and observed his 'environmental testing' thereof, on multiple occasions over several hours.
 - The documented very short time lapse between the *Cleansing the Mind* retreat dates (April 19-21, 2002) and the Dr. Burpee medical-verification-of-restored-vision date (May 3, 2002).

'Once I was blind, but now I can see...'

Truly a miracle?

- The healing was *permanent*; Greg retains normal vision — for a now 57 year old man — as I write this paragraph in late April 2016. A couple of days ago Travis Hunt, who's still in touch with Greg, wrote me that...

“Greg has normal aging eyes now. I think he has started wearing 'cheaters'. :-)”

...14 years after instantly regaining his lost central vision.

'Once I was blind, but now I can see...'

Appendix A: Greg Spencer evidence analysis

In some miracles, the changes are unambiguous. For example, I've written 'Adult small intestines CAN'T regenerate, but...' in the parent book — *Bridges for honest skeptics* — about the *verified naturally impossible* regeneration of a man's almost-destroyed small intestine — a medically obvious transformation. However, 'before' and 'after' eye conditions are less obvious, requiring more effort to establish high evidential certainty of a miracle. Therefore, in this appendix I look in detail at the evidence for the ['Once I was blind, but now I can see...'](#) account of Greg Spencer's restoration of sight.

I have mostly ignored Greg's, Travis Hunt's, and Randy Webb's testimony in this analysis, except in one argument near the end — not because those statements are unimportant (I think they're *very* important), but because I want to focus primarily on medical evidence and government documentation to satisfy those who may not accept *any* testimony.

Did Greg truly have irreversible vision loss?

Did Greg truly have irreversible vision loss?

It's far easier for a person to fake *lack* of adequate sight (the 'before' condition in Greg's account) than to demonstrate the *possession* of good sight (Greg's 'after' condition) — just as generally in life it's usually easy to fake *lack* of an ability but hard to demonstrate *possession* of that ability. Therefore, in this account we most importantly need to firmly establish Greg's 'before' condition: a serious loss of central vision.

To do that, I'll mostly analyze the 'before' data shown in ['Once I was blind, but now I can see...'](#), [Figure 1](#) through [Figure 9](#). My efforts to understand the data in detail will hopefully translate to *your* better understanding of the data.

Though this analysis substantially reflects my extensive online research to understand the nature and impact of the 'before' data, I needed help with questions that I couldn't address. Therefore, parts of the analysis include the results of a detailed ('level 3') paid consultation with online retina specialist 'Dr.

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

Rick' [at <http://www.justanswer.com/eye-health/>]. Dr. Rick (last name obviously withheld from users to avoid abuse of the service) has been a board-certified ophthalmologist since 1994, with a retina sub-specialty. He's a retinal surgeon. I'll attribute his inputs to my analysis as appropriate — continuing to refer to him simply as 'Dr. Rick' (however unsophisticated that sounds, a bit like how a child might refer to his/her pediatrician). Note that, over multiple communications with Dr. Rick, I was impressed that he moved from initially “uncomfortable” calling Greg's account a miracle to seemingly greater confidence as I supplied more data (the quantity of which was nonetheless time- and cost-restricted to *far* less evidence than I've provided you in this account).

Dr. Weleber's evaluations and diagnosis

The primary evidence of Greg's eye condition comes from Dr. Weleber's letter and attachments, [Figure 1](#) through [Figure 5](#). Dr. Richard G. Weleber is a board-certified ophthalmologist at Oregon Health and Science University (OHSU) with subspecialties in retinal dystrophies, congenital/genetic disease, diabetic retinopathy, and macular degeneration. He's both a cli-

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

nician and a researcher. [Information obtained on 10/23/2014 at <http://www.ohsu.edu/xd/health/services/providers/index.cfm?personid=816>.]

Dr. Weleber letter — page 1, paragraph 1, sentence 1

Quote

"On May 21, 1999, I saw Greg Spencer, the 40-year-old gentleman who you referred for evaluation because of his failing central visual acuity."

Comment

Nothing special here, except establishment of Greg's age and calendar date at the time of the examination — relevant to other statements in the doctor's letter.

Dr. Weleber letter — page 1, paragraph 1, sentences 2 to 3

Quote

"At about age 12-13, he began to experience reduction of vision, and his parents were told that he had swelling of the retina. Apparently the

Did Greg truly have irreversible vision loss?

vision improved in about 10 months and eventually came back to the 20/30 to 20/40 level, which he maintained for many decades.”

Comments

RETINAL SWELLING

Though the nature of Greg's adolescent “retinal swelling” was not identified, leaving uncertainty about the meaning of this term, my online searches of the term “retinal swelling” have typically pointed to a condition called ‘Cystoid Macular Edema’ (CME).

“The American Academy of Ophthalmology Preferred Practice Patterns defines Cystoid Macular Edema (CME) as retinal thickening of the macula due to a disruption of the normal blood-retinal barrier; this causes leakage from the peritoneal retinal capillaries and accumulation of fluid within the intracellular spaces of the retina, primarily in the outer plexiform layer. Visual loss occurs from retinal thickening and fluid collection that distorts the architecture of the photoreceptors. CME is a leading cause of central vision loss in the

Did Greg truly have irreversible vision loss?

developed world.” [http://eyewiki.aao.org/Cystoid_Macular_Edema under “Disease”]

Though chronic CME (e.g. greater than 6-9 months) can require medical intervention and cause damage,

“CME is usually self-limiting and spontaneously resolves within 3-4 months.” [http://eyewiki.aao.org/Cystoid_Macular_Edema under “Prognosis”.]

Note that the documentation of Greg’s middle-age vision loss does **not** suggest retinal swelling or CME.

SIGNIFICANCE OF THIS EPISODE

Does this youthful episode of self-correcting vision loss confound the validity of Greg’s middle-age vision restoration as a miracle? I address that question subsequently in this appendix in [Encore performance of youthful sight regeneration?](#) and conclude ‘No’ — for multiple reasons.

Did Greg truly have irreversible vision loss?

Dr. Weleber letter – page 1, paragraph 1, sentences 6 to 7

Quote

"However, because of difficulty with his central acuity, this began to become very difficulty [sic] for him over the past several months. His visual acuity was still 20/40 in August of 1998, but in April of this year the visual acuity had dropped to the 20/60 level and he stopped driving entirely".

Comments

Even Greg's initial vision loss, which subsequently worsened, was serious enough to stop Greg from driving. Given that later notes in Dr. Weleber's letter imply that Greg's later advanced vision loss could not be mitigated with corrective lenses, perhaps the 20/60 vision could not be corrected either — at least not enough to let him drive.

Did Greg truly have irreversible vision loss?

Dr. Weleber letter – page 1, paragraph 2, sentences 1 to 2

Quote

"Without correction his visual acuity today was CF at two feet, 20/400 letters at near in the right eye, and 20/200 no improvement with pinhole at distance, 20/200 letters at near, left eye. The near acuities were with a +2.00 sphere reader in each eye."

Interpretive comments

- "...CF at two feet" refers to... '**C**ounting **F**ingers':
"A method of recording vision in patients who are unable to identify any optotype on an acuity chart. If a patient correctly counts the numbers of the examiner's fingers shown, this is recorded with the distance at which it is performed." [Millodot, *Dictionary of Optometry and Visual Science, 7th edition*, Butterworth-Heinemann, 2009 — quoted as of 10/9/2014 from <http://medical-dictionary.thefreedictionary.com/counting+fingers>]

Did Greg truly have irreversible vision loss?

- "...right eye...20/200...at distance..." most generally refers to some variant of the Snellen-chart eye test to which most of us have been subjected (sometimes a *variable digital screen*, vs. a printed chart). The patient covers one eye and tries to read the smallest line possible on an eye chart actually or effectively 20 feet away. Technically,

"Snellen acuity is given in terms of a Snellen fraction S , which is defined as:

$$S = \frac{\text{Greatest distance a subject can just read a given line on chart}}{\text{Greatest distance a 'normal' observer can just read the same line"}}$$

[As of 10/20/2014, see <http://spie.org/x32356.xml>]

Greg's 20/200 vision effectively meant that Greg needed to be 20 feet from a line on the Snellen chart that a normal-vision person (20/20) could read at 200 feet away.

- The phrase "*20/200 no improvement with pin-hole at distance*" meant that Greg's distance vision loss was *not* related to eye-lens issues

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

as in myopia (nearsightedness). Looking through a pinhole eliminates effects of lens refraction in a patient's eye.

"An effective tool to determine if distance visual acuity can be corrected with a change of glasses or contact lenses is the pinhole disk. The pinhole disk admits only central rays of light, that do not need to be refracted by the cornea or lens to fall to a point on the retina as opposed to a circle of blur. A single pinhole of not more than 2.4mm or a multiple circular arrangement of 1.0mm pinholes can be used. Upon reevaluation with the pinhole, if a patient's visual acuity improves two or more lines, there is probably a refractive error present [in his eye], and refraction (evaluation for corrective lenses) should be performed before any further testing. *If the acuity is not improved with pinhole evaluation, it is likely that the cause of the decreased visual acuity is not refractive, and further ophthalmologic evaluation is indicated...*"

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

<Emphasis is mine.> [Krissa Drentlaw, *Visual Acuity: The Critical Measure*, Association of Technical Personnel in Ophthalmology, p. 7. As of 10/9/2014, available at <http://www.atpo.org/Documents/New/Articles/Visual%20Acuity%20The%20Critical%20Measure!.pdf>]

- The “at near” in “...20/400 letters at near in the right eye,... 20/200 letters at near, left eye....” refers to having the patient holding a card 14 inches from their right and left eyes — one at a time — and reading the smallest line on the card that they can. (The evaluation tool can be a *variable digital screen*, vs. a printed card.) The line they can read shows the person's ability to see the details of near objects. Though the card has tinier letters than the Snellen chart, the terms of visual acuity are similar (20/20...20/50....20/200 etc.) Note that Greg's right eye had worse *near* acuity (20/400) than *far* acuity (20/200).
- “The near acuities were with a +2.00 sphere reader in each eye” apparently states that

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

Greg had +2-diopter corrective 'reader' lenses in front of his eyes during the near-acuity tests, apparently to correct for age-related farsightedness (presbyopia). The term "sphere" indicates that the correction was for *non-astigmatic* farsightedness.

Could a patient fake acuity-test results?

In general? — Yes. Patients are in control of reporting what they say they can read. Therefore, they can report that falsely — though *good* acuity would be difficult to fake (unless a patient memorized a conventional — printed, vs. variable digital — Snellen chart).

Concerning bad-vision eye chart acuity tests, Dr. Rick noted that, "They could be faked and they are faked all the time but faking good vision is almost *impossible* to do nowadays with computer generated, variable vision charts." <Emphasis is mine.> The presently available data don't indicate whether or not the vision charts used in Greg's vision tests were digital.

In Greg's case? — Unless Greg had educated himself in advance about the pinhole test, he

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

wouldn't have known how to fake those results. Moreover, regarding Greg's character, he's a low-key guy who only very reluctantly shared his testimony for the *Jesus of Testimony* video; he doesn't trumpet his story for gain. And if he had faked the acuity tests — and gotten disability benefits because of his bad vision — what would have motivated him to inform the Social Security Administration of his vision improvement (an action implicitly confirmed by [Figure 9](#) of '[Once I was blind, but now I can see...](#)')?

- ...given that his notification would result in *loss* of further disability payments — when Greg could have easily faked continuing bad vision and received free money indefinitely, given the natural *irreversibility* of macular degeneration.
- ...given that his notification would predictably result in the hassle of a fraud investigation.

Greg's request for the benefits to stop following restoration of his vision (an action implicitly confirmed by [Figure 9](#) in '[Once I was blind, but now I can see...](#)') testifies to his character — and sug-

Did Greg truly have irreversible vision loss?

gests a likelihood of honesty about the miracle event as well.

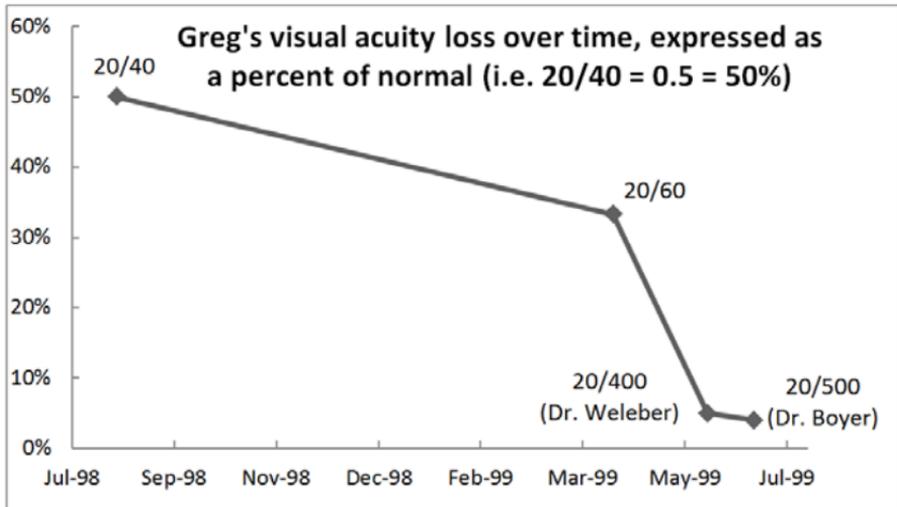
More importantly, however, hard-to-fake Goldmann perimetry visual field tests and examination of his interior eye surfaces (the fundus of each eye) — discussed in subsequent sections of this appendix — definitively showed serious loss of central vision prior to the miracle.

Multiple acuity data points: failing vision over time

[Figure 10](#) below, which I plotted for Greg's right eye from data in Dr. Weleber's and Dr. Boyer's letters, shows a gradual and then more rapid visual acuity loss over four eye exams, culminating in leveling-off of the deterioration process. The final data point comes from an independent acuity test done by optometrist Dr. Boyer (see [Figure 6](#)).

Did Greg truly have irreversible vision loss?

Figure 10 Greg's vision loss over time



Note that the visual acuity loss is *not* represented by a single data point that could be — without any neighboring points to compare to — an 'outlier'. Two independent measurements of the most severe condition are close and logically changing in the negative direction (worsening vision). Two data points are statistically more reliable than one.

Dr. Weleber's diagnoses of Greg's macular degeneration include no comments about or distinctions

Did Greg truly have irreversible vision loss?

between so-called 'dry' and 'wet' macular degeneration and mentions no blood-vessel abnormalities in Greg's eyes. Therefore, **we can't draw conclusions about those distinctions.** However, the above-plotted trend of initially slow loss of acuity, followed by a very rapid loss of acuity, then followed by a slower loss of acuity is at least logically *consistent* with...

- ...Greg initially having the more-slowly-deteriorating 'dry' form of macular degeneration...
- ...followed by rather precipitous deterioration to the more serious 'wet' form...
- ...followed by slower deterioration of what little central vision was left.

It seems at least *consistent* with the following:

"Dry AMD [age-related macular degeneration] affects about 85% of those with the disease and causes *gradual* loss of central vision, sometimes starting in one eye. *Wet AMD*, which accounts for 90% of all severe vision loss from the disease, often involves a *sudden* loss of central vision. *Most people with the wet form of AMD previously had the dry form.*"

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

<Emphasis is mine.> [As of 11/3/2014, see <http://umm.edu/health/medical/altmed/condition/macular-degeneration.>]

Conclusions

Serious visual acuity loss seems real on the basis of acuity tests alone, given the number and trending of independent acuity data points and Greg's character — voluntarily ending disability payments when otherwise no one but him would have to know of his remarkable restoration of sight. Moreover, even a person of poor character who might casually fake a given test of poor visual acuity would need substantial knowledge and creativity to fake the vision-loss trend we see in the above four-point plot.

Did Greg truly have irreversible vision loss?

Dr. Weleber letter – page 1, paragraph 2, sentence 3

Quote

"Tonopen intraocular pressures were 15 mm Hg OU".

Comments

This is normal. "Normal intraocular pressures average between 12-22 mm Hg." [See *What is considered normal eye pressure?*, Glaucoma Research Foundation. Available as of 10/9/2014 at <http://www.glaucoma.org/q-a/what-is-considered-normal-pressure.php>] This measurement for Greg indicates the lack of glaucoma.

Did Greg truly have irreversible vision loss?

Dr. Weleber letter – page 1, paragraph 2, sentence 4

Quote

"We were unable to improve the vision with manifest techniques."

Comments

Manifest means "Clearly revealed to the mind or the senses or judgment" [WordWeb]. Dr. Weleber's statement above implies that he was unable to improve Greg's vision with any obvious techniques, presumably including corrective lenses. The pinhole tests, described previously, also suggest that eye-lens refraction was not responsible for his vision loss, seemingly confirming the futility of corrective refraction (glasses or contact lenses) as a solution.

Conclusion

Greg's *central* vision loss was not correctable.

Did Greg truly have irreversible vision loss?

Dr. Weleber letter – page 1, paragraph 2, sentence 5

Quote

"Goldmann perimetry visual fields performed the previous day disclosed dense central scotomas in each eye, with the larger more dense scotoma being present in the right eye."

Comments

1. "A scotoma...is an area of partial alteration in the field of vision consisting of a partially diminished or entirely degenerated visual acuity that is surrounded by a field of normal – or relatively well-preserved – vision." [Wikipedia, *Scotoma*.] Each of our eyes has a normal scotoma called the 'Blind spot' where the optic nerve exits the retina. However, in macular degeneration an *abnormal* scotoma obscures normal central vision – which is critical for many human activities and is the primary focus of vision in well-illuminated environments. The shaded areas of Greg's Goldmann plots, [Figure 2](#) and [Figure 3](#) in '[Once I was blind, but now I can see...](#)' definitively indicate

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

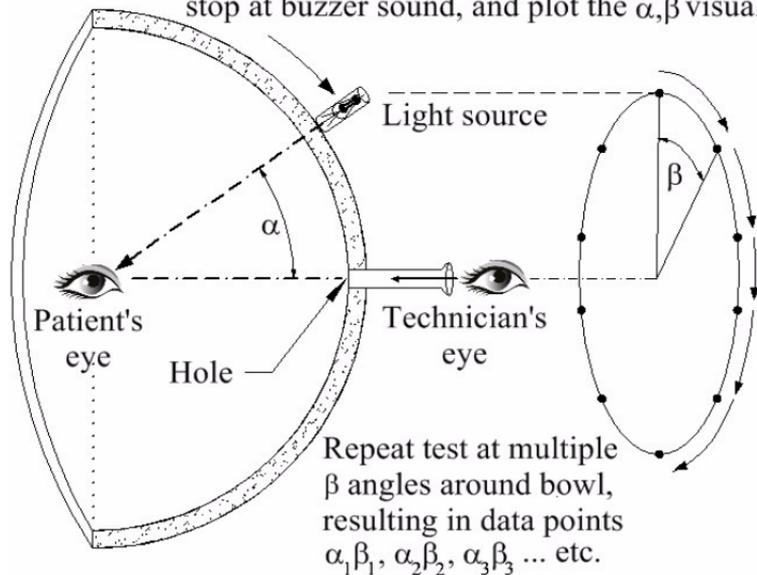
that Greg had serious loss of central vision — macular disease.

2. Here's what I've learned about Goldmann perimetry tests that might help you better understand that aspect of Greg's evidence.
 - a. The semi-blindfolded, head-positioned patient fixates the focus of his/her exposed eye on a hole at the center of a large hemispherical bowl in a darkened room.
 - b. In the initial tests, a technician behind the bowl moves the *angle* of a *light* spot *inward* towards the hole — starting at a high light-source-to-hole angle outside the range of peripheral vision, moving into the patient's field of peripheral vision and, ultimately, toward the patient's field of central vision. I'll call the light-source-to-hole angle *alpha* (α). I illustrate this understanding of the process below in [Figure 11](#).

Did Greg truly have irreversible vision loss?

Figure 11 Schematic understanding of Goldmann perimetry^a

At a chosen circumferential angle β and light setting, decrease the light-source-to-hole angle α at $\sim 3\text{-}5^\circ/\text{sec}$, stop at buzzer sound, and plot the α, β visual-field point.



^aThe left half of the figure shows a cross section of the hemispherical bowl (think of placing a knife on the central hole and cutting the bowl in half to help illustrate the α -angle). In the right half of the figure, the 'circle-on-edge' illustrates the β angles (rotation angles about the center-hole axis) at which technician takes multiple measurements.

Did Greg truly have irreversible vision loss?

- c. When the patient first sees the light — when the light is first detectable in their field of vision — he/she presses a buzzer. The technician then immediately stops the movement, notes the light spot angle *alpha* (α) relative to the patient's line of sight to the bowl's central hole. The technician also notes the circumferential angle of the light source about the central hole *beta* (β) and plots the α, β coordinates on a graph like that shown in [Figure 2](#) and [Figure 3](#) of ['Once I was blind, but now I can see...'](#).
- d. The technician repeats this procedure at different β angles. Each point on the graph, $\alpha_1, \beta_1, \alpha_2, \beta_2, \alpha_3, \beta_3, \dots$ etc. represents the intersection of the particular light-source-to-hole angle α at which the patient first sees light and the corresponding circumferential angle β .
- Each such point on the graph corresponds to a location on the inside surface of the eye opposite the lens (i.e. on the 'fundus').*

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

NOTE *Clarification of angle β* — Consider the Goldmann-test bowl like a half grapefruit, which you've cut perpendicular to the axis of the stem — the location corresponding to the Goldmann bowl's central hole. Each grapefruit segment you see is roughly triangular, with the apex of each triangle at the stem axis. The tasty segments of the half grapefruit look roughly like a pie cut into ~triangular slices, with the apex of each slice at the center of the pie.

When we eat the first grapefruit segment we leave a roughly-triangular hole; let's call the apex angle of that first hole β_1 . When we eat the next segment, the roughly triangular hole is now about two times larger, with an apex angle β_2 . Each time we eat another segment, we increase the apex angle of the hole to $\beta_3, \beta_4, \beta_5, \dots$ etc. until we've emptied the grapefruit (at which point angle β is 360 degrees).

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

Analogously, the Goldmann technician moves the light source around the bowl 'one additional grapefruit segment' at a time, each time: 1) noting the current β angle, 2) performing the test, 3) noting the corresponding α angle at which the patient rings the buzzer, and 4) plotting the α, β point.

- e. The technician repeats the above procedure — steps a through d — at variable light-spot intensities and sizes. For example, the designations I-3e, I-4e, III-4e etc. on Greg's Goldmann plots designate such light-spot intensities and sizes. Each 'ring' on a Goldmann plot (called an 'isopter') represents all of the points corresponding to one specific light-spot intensity and size combination.
- f. If a central scotoma is found, the technician may then modify the procedure. He/she moves the α angle of the light-spot *outward*, starting at *low* angles (small α values), corresponding to the insensitive scotoma region, and then moving toward larger angles (higher α values) — again

Did Greg truly have irreversible vision loss?

stopping and plotting angles as soon as the patient presses the 'I see the light' buzzer. The technician may also check for *static* detection of light at various points in or around the scotoma region — each time fixing the light spot at a particular combination of α, β angles, turning the light on, and asking whether the patient sees it.

For more information about Goldmann tests:

- First see Inci Dursu *et al*, *Understanding Visual Fields, Part I; Goldmann Perimetry*, Journal of Ophthalmic Medical Technology, June 2006 (accessible as of 10/11/2014 at <http://www.jomtonline.com/jomt/articles/volumes/2/2/visualfields.pdf>)
 - Then optionally see Carol Pollack-Rundle, *Goldmann Visual Fields: a Technician's Guide*, Association of Technical Personnel in Ophthalmology (accessible as of 10/11/2014 at <https://www.atpo.org/Documents/New/Articles/GOLDMANN.pdf>)
3. Someone might ask, "If Greg pushed a buzzer at each point on the Goldmann field plots, could he have faked the exam to make the

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

plots look the way he wanted...to make his vision seem worse than it was?" I.e., could he have pressed the buzzer deliberately at inappropriate points?

Faking would be very difficult for the following reasons:

- Firstly, a Goldmann-test technician monitors a patient's focus through an eyepiece in the center of the bowl, ensuring that focus remains fixated at that point — critical for mapping light detection points in the eye. Greg's technician made the following notation on his right-eye Goldmann plot: "coop/fix - good" (and apparently similar notation, cut off at the beginning of the 'g' on the left-eye plot), presumably indicating that Greg was cooperative and maintained eye fixation on the central point of the bowl.
- Fakers need to guesstimate the angle from which the light is shining — but they cannot see the light until their eye is capable of detecting it, at which point the technician records numbers they can't influence.

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

- Even if a faker were very cognizant of how the test works (which most people are not without research), experience has established that he/she would have trouble faking a coherent pattern. *Understanding Visual Fields, Part I; Goldmann Perimetry*, page 8, notes that the Goldmann test...
“...is extremely useful in patients with *functional* visual loss. These patients have no organic basis for their decreased vision. They run the gamut from malingerers (to feign for gain) to the psychologically depressed (subconscious loss of vision). Certain visual field defects are indicative of functional patients. These include spiraling isopters, crossing of isopters, and severely constricted fields.”

If you look at the diagrams in *Understanding Visual Fields, Part I; Goldmann Perimetry* that illustrate such characteristics (see PDF-page 9 of that document) you'll quickly note that Greg Spencer's Goldmann plots do *not* exhibit any such characteristics.

Did Greg truly have irreversible vision loss?

4. Retina specialist Dr. Rick, *before* seeing Greg's Goldmann field plots, expressed reservations about using that technology for severe central vision loss — though he later noted that it's more generally a very good tool in competent hands, which he believes the staff at OHSU likely possesses. However, after seeing the unusually detailed, low scatter Goldmann field plots at the end of our dialog, he noted that, "You can suggest that they did a very good job with the best reliability possible and very high attention to detail." His concern seems not to be the *fact* of significant central vision loss defined by the Goldmann plots but the *quantification* of that loss by these tests. Commenting on the Goldmann technician's notes of "coop/fix - good" (see [Figure 2](#) in '[Once I was blind, but now I can see...](#)'), he indicated that "with that size and density of a central scotoma, while the patient may have cooperated to the best of his ability, maintaining fixation during the test would have been very, very difficult." Excellent Goldmann results implicitly require excellent patient fixation (steady focus of the eye on the central hole in

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

the Goldmann-perimeter bowl) — tough to do with severe central vision loss.

Conclusions

The Goldmann tests genuinely indicate that Greg had serious central vision loss, especially in the right eye, regardless of how precisely that loss was quantified. Greg's condition was neither faked nor psychosomatic.

Dr. Weleber letter — Last sentence of page 1; page 2, paragraph 1, sentences 1 and 2

Quote

"Ocular motility, external examination, and biomicroscopy were normal. On fundus examination, the optic nerve heads were pink with 0.3 cup-to-disc ratio, and the retina vessels, peripheral choroid, and peripheral retina all unremarkable and normal in appearance..."

Comments

These are apparently all 'normal' findings, some of which relate to the peripheral (vs. central) areas of Greg's vision.

Did Greg truly have irreversible vision loss?

Dr. Weleber letter — Page 2, paragraph 1, sentence 3

Quote

"The foveal region had rather striking retinal pigment epithelial mottling bilaterally in an oval distribution of about one disc diameter in size, greater for the right eye than for the left eye."

Comments

- The foveal region is in the center of the macula. To appreciate the critical importance of the fovea for central vision, note the following:
 - *"Humans are diurnal creatures. We tend to be most active during the day, or we recreate these high light levels with manufactured sources when we are active at night. Thus most of human visual experience is mediated by cones. This cone dominance occurs despite a prominent anatomical bias: the human retina is 95% rods and only 5% cones, and this minority of cones is concentrated in a tiny central portion of*

Did Greg truly have irreversible vision loss?

the retina, the fovea.” <Emphases are mine.> [Nouchine Hadjikhani and Roger B.H. Tootell, *Projection of Rods and Cones Within Human Visual Cortex*, Human Brain Mapping, Vol. 9, 2000, pp. 55–63. As of 10/30/2014, available at: http://www.ibrarian.net/navon/paper/Projection_of_Rods_and_Cones_Within_Human_Visual_.pdf?paperid=8824245]

- “...*greater for the right eye than for the left eye*” correlates with worse vision in the right eye than in the left eye.
- “...[optic] *disk diameter in size*” refers to the size of the blind spot over the exit point of the optic nerve.

The average size of the optic disk is 1.76 mm wide × 1.92 mm high. [http://en.wikipedia.org/wiki/Optic_disc] and the size of the fovea is about 1.5mm [http://en.wikipedia.org/wiki/Fovea_centralis]. Therefore, Dr. Weleber's statement implies that the entire fovea was mottled.

- Per retina specialist Dr. Rick:

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

- One-disk-diameter foveal mottling, at least if centered over the fovea (as implied in Dr. Weleber's 1999 letter) *would implicitly decrease central vision* — though not necessarily result in visual acuities as bad as 20/200 or 20/400, given a multitude of possible causes for such mottling.
- "If the RPE [retinal pigment epithelium] is damaged, the photoreceptors die and **they do not come back** in clinical situations." <Emphasis is mine.>
- "Retinal pigment epithelial mottling, once present, **never goes away**." <Emphasis is mine.>
- In answer to another question, he concurred that Greg indeed had some *significant and irreversible* central vision loss, regardless of how precisely that loss was quantified.

Note also that *early* in my dialog with Dr. Rick — at a more skeptical point *before* he knew of and was impressed by Dr. Weleber's qualifications as an OHSU retina specialist and was provided further data — he stated the following about the

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

natural irreversibility of such extensive vision loss:

"I believe that this man may have decreased vision but I very much doubt that it was 20/400 and 20/200 and then got better. **Retinal damage that you are talking about does not improve.**" <Emphasis is mine.>

Conclusion

Dr. Weleber's fundus examinations indicate, if not precisely quantify, significant irreversible central vision loss.

Dr. Weleber letter – Page 2, paragraph 1, sentences 4 and 5

Quote

"Also on May 20, 1999, Greg had an electroretinogram which disclosed normal amplitudes and implicit times for both rod and cone mediated responses. The final 45-minute rod psychophysi-

Did Greg truly have irreversible vision loss?

cal threshold was mildly elevated above normal in each eye."

Comments

Retina specialist Dr. Rick noted the following about the above quote: "**Exactly what I would expect** the ERG [electroretinogram] to show **given what you have told me** [via other Weleber quotes]. **A very good data point.**" <Emphases are mine.>

Conclusions

Per Dr. Rick, these results apparently confirm Greg's **naturally irreversible** central-vision loss.

Dr. Weleber letter – Page 2, paragraph 2, sentence 1

Quote

"All things considered, Greg appears to have a macular degenerative process in each eye that

Did Greg truly have irreversible vision loss?

has finally resulted in legal blindness status for his better seeing left eye."

Comments

- Dr. Weleber effectively diagnoses **macular degeneration** here. (See more details of his diagnosis in "Dr. Weleber letter — Remainder of letter".) That's important.
- "In 1972, the Aid to the Blind program and two others combined under Title XVI of the Social Security Act to form the Supplemental Security Income program which currently states:
 'An individual shall be considered to be blind for purposes of this title if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.'" <Emphasis is mine.>
 [http://en.wikipedia.org/wiki/Blindness#United_States]
- Greg had 20/200 vision in his better (left) eye that was uncorrectable. (Recall prior Dr. Weleber quote, "We were unable to improve the vision with manifest techniques.")

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

- The Social Security Administration letter ([Figure 9](#)), stating the result of the possible-fraud investigation, acknowledges the legitimacy of Greg's former legally-blind status — and the "remarkable return of your vision."

Dr. Weleber letter — Page 2, paragraph 2, sentence 2

Quote

"Because of the rather sudden fall in acuity the most likely situation was that he had a tight ring scotopic around fixation with a central island of vision for the left eye that finally got 'snuffed out' leaving him with the large central scotoma."

Comments

My research on this came up mostly empty — especially given that "scotopic" refers to rod-cell peripheral vision. Initially Dr. Rick was baffled too, noting that "...a tight ring scotopic around fixation is not common terminology." However, he subsequently speculated that Dr. Weleber might have inadvertently typed the word "scotopic" instead of "scotoma", which would make sense.

Did Greg truly have irreversible vision loss?

My interpretation: **If** the word “scotoma” was indeed intended instead of “scotopic”, then Dr. Weleber apparently perceived that at one point — presumably before the precipitous final loss of central vision — a ring-shaped, sight-impairing scotoma surrounded an “island” of still-functioning central vision in the left-eye macula. But that “island” of central vision ultimately also became functionally “snuffed out” and became a scotoma as well. It therefore merged with the ring scotoma, resulting in a combined large central scotoma that left Greg with severely impaired central vision.

Dr. Weleber letter — Page 2, paragraph 2, sentence 3

Quote

"The central scotomas on Goldmann perimetry appear larger than one would expect from just the fundus appearance alone. Nevertheless, I believe that the scotoma sizes are correct and his macul-

Did Greg truly have irreversible vision loss?

opathy is cause for his marked reduction of acuity.”

Comments

Dr. Weleber is convinced that the Goldmann-measured scotoma size is fundamentally correct, despite a lesser severity of central vision loss suggested by fundus observations. My retina consultant Dr. Rick is not as confident of this quantification, for reasons discussed previously. (See comment 5 at the end of [Dr. Weleber letter – page 1, paragraph 2, sentence 5.](#)) However, as previous discussions in this analysis indicate, the **fact** (vs. the **degree**) of significant, irreversible central vision loss is not in doubt.

Dr. Weleber letter – Remainder of letter

The rest of Dr. Weleber's letter primarily discusses measures to help Greg deal with the diagnosis and hypothesizes genetic reasons for the vision loss. However, please note the following:

- Dr. Weleber's comments on page 3, paragraph 2, sentence 1, noting...

Did Greg truly have irreversible vision loss?

“the *high likelihood* that this is a genetic form of *macular degeneration*.” <Emphasis is mine.>

...a yet firmer statement of his judgment on page 2, paragraph 2, sentence 1 that...

“All things considered, Greg appears to have [present tense] a macular degenerative process in each eye that has finally resulted in legal blindness status for his better seeing left eye.”

- The fact that macular degeneration is considered irreversible — adding to Dr. Rick comments about the irreversibility of Greg's condition on page 2, paragraph 1, sentence 3. Consider the following statements:
 - “With all the attention given to macular disease, doctors have not discovered the 'silver bullet.' Macular degeneration is *irreversible and incurable*. Patients diagnosed with the disease are told that their vision will slowly decrease. At best, therapy is palliative. The attempt is to maintain the size of their central

Did Greg truly have irreversible vision loss?

blind zone so that it does not expand.”

<Emphasis is mine.>

Ophthalmologist T. Ramsey Thorp, M.D., *The Laying On of Hands*, Hamilton Books, 2005, pp. 33 to 34. These pages are available, as of 9/30/2014, at: <https://books.google.com/books?id=7LGzx29J0YgC&printsec=front-cover&dq=isbn:0761832491&hl=en&sa=X&ei=9JS1VJK9HoyoNvnzgPgJ&ved=0CB8Q6AEwA#v=onepage&q&f=false>

- “Are there any cures for macular degeneration? Once the damage has occurred, it's considered *permanent and irreversible*.”
<Emphasis are mine.>

Mitchell Hatch M.D, *Macular degeneration is irreversible*, 'Ask Dr. H', The Spokesman Review, September 14, 1999, page 02. Available as of 9/30/2014 at <http://news.google.com/newspapers?nid=1314&dat=19990914&id=PY9XAAAIBA&sjid=IfIDAAAIBA&pg=2882,4188359>

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

- "The utmost important consequence of macular degeneration is *irreversible vision loss.*"
<Emphasis is mine.>

Causes and consequences of macular degeneration, eMedWiki. Available as of 9/30/2014 at: http://php.med.unsw.edu.au/medwiki/index.php?title=Causes_and_consequences_of_macular_degeneration

Note also Doctor Weleber's comment that,

"The news of his visual acuity reaching the legal blindness status was quite a shock for Greg and he will need considerable support..."

Of course a good actor *could* feign shock. However, such an effort might not fool an astute medical professional who's seen hundreds or thousands of patients and would seemingly require one more element of coordinated planning by a faker. Therefore, the "quite a shock" statement further suggests that Greg didn't try to get disability payments by faking irreversible central vision loss — *the existence of which is independently attested to by the medical evidence discussed above.*

Appendix A: Greg Spencer evidence analysis

Did Greg truly have irreversible vision loss?

Dr. Boyer letter

I won't go through Dr. Boyer's letter in detail, as I did for Dr. Weleber's letter, except to highlight these points:

- Dr. Boyer subsequently and independently confirmed seriously compromised visual acuity, which had in fact deteriorated further by that point in time: 20/300 and 20/500, vs. 20/200 and 20/400 before. (Note that two sets of independently measured data points are generally statistically more reliable than one.) Unless Greg faked both tests, which I strongly doubt for multiple reasons discussed previously, his legal status of blindness seems even more certain. (Recall my earlier plot in [Dr. Weleber letter — page 1, paragraph 2, sentences 1 to 2](#), which includes Dr. Boyer's 20/500 right-eye data point.)
- Moreover, Dr. Boyer's recommendations for polarized filters, a magnifier of a specific power, specific prescriptions for near-vision lenses (positive-diopter numbers presumably for presbyopia), and specialized software appear to further confirm that Greg's vision was evaluated comprehensively, not haphazardly.

Appendix A: Greg Spencer evidence analysis

Was Greg truly healed of his blindness?

- That this letter and these recommendations are addressed to the Oregon Commission for the Blind, a state agency [http://www.oregon.gov/blind/Pages/about_us.aspx], seems to further confirm Greg's statutory blindness.

Was Greg truly healed of his blindness?

The following examines the 'after' evidence of [Figure 8](#) and [Figure 9](#) in '[Once I was blind, but now I can see...](#)' without the detail to which I subjected the 'before' evidence.

Could Greg's GOOD vision be ambiguous or faked?

Less detailed medical data is available to us for Greg's 'after' condition — that is, 'after' the remarkable restoration of his sight — than for his 'before' condition. *However, **less information is needed***. All we need is confirmation that his sight is now good, which is hard to fake.

- Again, the absence of good vision, just as the absence of any ability, is typically much harder to

Was Greg truly healed of his blindness?

establish than the presence of good vision. Regarding acuity tests, if I say I can't see letters on a chart in the ophthalmologist's office, or deliberately read them incorrectly, who's to know — unless the doctor later observes me doing something that I shouldn't be able to do with poor vision? That's why I dedicated so many pages of this appendix to examining 'before' data to establish beyond reasonable doubt that Greg had severe vision loss.

- By contrast, the presence of good vision, just like the presence of any ability, is hard to fake. If I falsely claim to be a good baseball pitcher, a minute or two on the mound will reveal my lie. If I falsely claim to be a skilled computer programmer, a few lines of code will reveal my lie. And if I falsely claim to have good vision, a few failures to read letters on an eye chart will reveal my lie. One could ostensibly buy and memorize a printed eye chart and fake good vision. However, as retina specialist Dr. Rick noted, it's virtually impossible to fake with digital eye charts, the letter patterns of which can be randomly constructed and so impossible to memorize. (Without the availability of further information, unfortunately,

Was Greg truly healed of his blindness?

we don't know whether the charts used to evaluate Greg's 'after' vision were digital.)

- It's impossible for a person with macular degeneration to fake a now-favorable-looking post-miracle eye fundus and macula, yet physical examination apparently revealed favorable changes. (See [Did Greg's eyes change physically?](#) below.)
- It's impossible to walk leisurely around town, with friends, and into the eye-doctor's office without revealing vision deficiencies. If a man can't read the 'Men's Room' sign, walks hesitantly because of inferior peripheral vision, cannot read instructions, cannot read a menu, etc., that will be obvious. It would have been impossible to read aloud, to Randy and Travis, license plates at a distance.
- It's impossible to successfully hold a normal job with vision as bad as Greg's was. Yet Greg willingly gave up disability payments, and the Social Security Administration declared him able to work.
- It's unlikely that the Social Security Administration ([Figure 9](#)) would close a year-long fraud investigation with a statement that effectively

Was Greg truly healed of his blindness?

says, "He really had horrible vision and needed our help and now has good vision and doesn't" if it weren't true.

Did Greg's eyes change physically?

Considering that, per retina specialist Dr. Rick, "Retinal pigment epithelial mottling, once present, never goes away," it seems that the 'before' and 'after' observations of the insides of Greg's eyes revealed substantial physical differences. Though Dr. Rick would like to see 'before' and 'after' fundus pictures and angiogram films — unfortunately unavailable to me — he noted that the following 'after' vision-restoration assessment...

*"Examination shows mild macular pigment scatter but no macular edema or deposits at this time."
(Dr. Burpee)*

"...is a **totally** different description of the state of his retina" <Emphasis mine> from the following 'before' vision-restoration assessment...

"...rather striking retinal pigment epithelial mottling bilaterally in an oval distribution of about one disc diameter in size." (Dr. Weleber)

Appendix A: Greg Spencer evidence analysis

Encore performance of youthful sight regeneration?

Encore performance of youthful sight regeneration?

Some individuals who consider this account in detail — myself included — may understandably wonder, or *have* wondered at some point, whether Greg's restoration of good vision in middle age could in some way have been an 'encore performance' of the vision restoration of his youth. I submit that we can virtually dismiss that possibility because of key dissimilarities between his youthful and middle-age visual situations. I discuss these dissimilarities in the next two subsections

Analysis

See [Table 1](#) below and the bullet list that follows.

Encore performance of youthful sight regeneration?

Table 1 Youth vs. middle-age vision-loss scenarios

| Youth | Middle age |
|---|--|
| Reported diagnosis of retinal swelling. | No mention whatever of retinal swelling in documentation. |
| By implication, compromised vision was <i>correctable</i> enough for functionality. | Greg's vision was declared <i>not correctable</i> (see Dr. Weleber letter — page 1, paragraph 2, sentence 4) |
| Greg apparently not seriously incapacitated or legally blind. | Declared legally blind in detail. Given official government help. (See Dr. Boyer letter.) |
| Loss was apparently <i>not</i> diagnosed as <i>irreversible</i> (logical if indeed his condition was CME, as discussed above in Retinal swelling). | Naturally irreversible. See Dr. Weleber letter — Page 2, paragraph 1, sentence 3 , Dr. Weleber letter — Page 2, paragraph 1, sentences 4 and 5 , and Dr. Weleber letter — Remainder of letter |
| Acuity restored over about 10 months. | Acuity restored very quickly. Confirmed by observations of Greg's post-restoration behaviors and by date-closeness of retreat (Figure 7) and Dr. Burpee letter (Figure 8). |

Encore performance of youthful sight regeneration?

- *Different pathology* — The retinal swelling in Greg's youth apparently differs from the foveal epithelial mottling, large central scotomas, and diagnosis of macular degeneration in Greg's middle age.
- *Uncorrectability* — Apparently glasses or other corrective refraction could not help Greg in his middle age. That's further indicated by the results of the pinhole test ([Dr. Weleber letter — page 1, paragraph 2, sentences 1 to 2](#)).
- *Irreversibility* — Multiple factors indicated that Greg could **not** have **naturally** regained his sight after his **irreversible** middle-age vision loss.
- *Legal blindness* — The government had every right to wonder whether Greg may somehow have previously faked blindness to get disability payments, *because his prior condition would have been considered irreversible*. The Social Security Administration understandably does not typically encounter or readily accept miracles. However, it obviously *looked at the data* — presumably with the assistance of their own eye-disease experts — and *ended up convinced* that Greg's prior blindness claims were genuine, and his remarkable restoration of sight was genuine as well.

Encore performance of youthful sight regeneration?

- *Rapidity of middle-age vision restoration vs. slowness of youthful restoration* — Greg’s report of the *suddenness* of his good-vision restoration is confirmed:
 - Retreat participants — two of whose comments I’ve reported — observed Greg’s irrepressible excitement about his renewed vision and his 'environmental testing' thereof, on multiple occasions over several hours.
 - The May 3, 2002 date of the Dr. Burpee letter about Greg, reporting the “remarkable return of his visual acuity” ([Figure 8](#)). It was written a mere 14 days after the April 19, 2002 *starting* date of the *Cleansing the Mind* retreat ([Figure 7](#)), at which Greg’s vision was restored.
 - Greg’s honesty — evidenced by 1) his voluntary notice to end a free ride from the government — apparently *promptly* after his vision restoration and 2) his willingness to endure a predictable investigation of possible disability-payments fraud. (Greg was exonerated. See [Figure 9](#), noting that the 5/3/02 Dr. Burpee letter was key evidence in that investigation.)

Conclusions

Greg's honesty buttresses the reliability of his report of *sudden* healing at the *Cleansing the Mind* retreat.

Bottom line

Though Greg may indeed have an inborn weakness that manifested itself in two widely spaced episodes of vision loss, *we need to consider Greg's middle-age vision loss and dramatic restoration completely on its own merits*. His middle-age vision loss and sudden restoration was clearly no 'encore performance' of the youthful scenario.

Conclusions

Does this evidence and analysis *prove* that supernatural intervention occurred? No, not *prove*. However, I submit, the realistic criterion for evaluating such evidence is *sufficiency*, not perfection. Even the most rigorous application of the scientific method — clearly inapplicable to one-time events or to the overwhelming majority of life's decision-making scenarios — rarely or never generates absolute proof, just varying degrees of confidence (albeit sometimes very close to

Conclusions

unassailable proof^a). *Legal* standards of evidence — not scientific research standards and often not even *forensic* standards^b — apply to such one-time events. I submit that if miracles were considered criminal events, the attestations supplied in this account — and in the two other medically attested accounts that accompany this one in the parent book, *Bridges for honest skeptics* — would easily convict the recipients in any legitimate court of law.

Of course not even *perfect* evidence, if such were even possible, would convince individuals whose worldviews — may I suggest *faith* commitments? — deny even the possibility of miracles. Prejudices aside, I suggest that the *best* explanation of Greg Spencer's data *unequivocally* favors ***a miracle***.

^aFor example, the second law of thermodynamics is generally considered virtually 'bulletproof', as are Newton's laws of mechanics when applied in non-quantum-mechanical, non-relativistic situations.

^bForensic evidence — often based on sophisticated scientific methodologies — isn't involved in the majority of criminal convictions, in contrast to common misperceptions. See 'How many critical LEGAL decisions are scientific?' in the parent book, *Bridges for honest skeptics*.

Endnotes

1. Summarized from:
 - Greg Spencer's testimony in the video *Jesus of Testimony* — Nesch Productions LLC, 2014 — starting at time 01:13. You can watch this informative video for free [<http://www.jesusoftestimony.com/watch/>], download a nominal-cost HD version at that same URL (recommended for seamless viewing), or purchase a DVD [<http://www.jesusoftestimony.com/store/>].
 - Medical and other evidence provided by Greg to the Nesch brothers (the video's producers), who have displayed it briefly in the video and made it available to me.
 - Private phone conversations with observers Travis Hunt on 12/12/2014 and Randy Webb on 12/17/2014 (and very briefly on 1/5/2015).
2. One such internet source is http://www.fact-book.org/wikipedia/en/a/ag/age_related_macular_degeneration.html

3. http://www.lyricsfreak.com/k/keith+green/rushing+wind_20077385.html