LOUISIANA FAMILY EYECARE

107 Terra Bella Blvd., Covington, LA 70433 (p): 985-875-7898 (f): 985-875-9844

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Testimony in Favor of S. 64

Chairwoman Lyons & Members of the Committee:

Thank you for allowing me to speak today. My name is Amy Puerto, and I am an optometrist in private practice in Covington, Louisiana, 45 minutes north of New Orleans in a parish that borders rural Mississippi. But I feel like I could be one of your constituents…and that's why I want to speak to you simply as an optometrist who has been performing the procedures outlined in this bill safely and responsibly for over a decade. I graduated optometry school in 2015. Today is my surgical clinic morning. I am not here to theorize about what optometry might be capable of — I am here as someone who lives this every week in clinical practice.

In my practice, post-cataract YAG capsulotomies are preformed weekly. Managing posterior capsule opacification for patients who had cataract surgery is part of my daily care whether it's discussing the condition with patients or making a clinical decision to schedule the patient for surgery. Selective laser trabeculoplasty for open angle glaucoma is primary surgical care. Evaluating narrow angles and managing acute angle closure glaucoma is part of all optometrists' comprehensive clinical decision-making. Removing benign eyelid lesions— particularly chalazion excisions — is part of my clinical skillset and, honestly, one of my most rewarding procedures to perform because of how immediately it helps a patient look, feel, and function better after other topical and systemic treatments failed.

Therefore, when I hear these procedures described as beyond optometry's scope, that does not reflect the education I received nor the everyday realities of my practice. For optometrists like me, the procedures outlined in S. 64 are not "advanced" procedures, they are skills and treatments integrated into the safe eye care I provide my patients daily, and my patients expect me to provide them.

I began optometry school in 2011 in Tennessee — a state that at the time did not yet have legislative authority for some of these procedures. Yet I was trained didactically and clinically in laser procedures, in management of surgical complications, and ordering then sending out lesions for reports. The education existed regardless of statute. That's important. Our schools prepare us, and continue to prepare students, for where eye care is going — not only where it currently is.

Fluorescein angiography, for example, has been taught in optometry schools for decades— including its risk of adverse effects. I learned it nearly fifteen years ago, and while it's not a major diagnostic tool outside of retina care, in preparing for this testimony, I was surprised to learn Vermont law did not already reflect optometry's training and board certification to perform this diagnostic testing. Not every optometrist may provide this diagnostic tool, just as Dr. Chris Brady mentioned in his testimony today doesn't preform every subspecialty procedure either.

But the training exists for both of us. The education exists. And the proven competency pathway exists.

Rest assured, S. 64 does not invent new skills for optometrists to learn. It recognizes training that often has already occurred — but with stringent guardrails… in fact, as I read through this bill, Vermont's regulatory safeguards will become the strongest in the nation.

It is true that no procedure should ever be considered "minor" in the sense that it is without consequence. When caring for another human being before surgery, patients are often anxious. Their blood pressure can rise. Some may even become lightheaded or pass out. But optometrists have been skilled and trained to prepare for those anticipated situations. We know patients move. They flinch. They swear. And in those moments — when a person is simply having a human response to stress — the provider must remain steady, calm, and prepared.

That gravity is not unique to one profession. It is inherent to all patient care.

Because of my training and years of practice, I approach every procedure with deep respect for anatomy, physiology, and the human condition. I am attentive to anxiety, vigilant about vital signs and bleeding risks, cautious and selective of the technique, medications, and instruments I use. Even more, surgical judgment is not just about being able to perform a procedure — it is about recognizing when not to perform it. If someone is not an appropriate candidate under my care, I do not proceed.

The visuals shown two weeks ago by ophthalmology were excellent — truly. We see those same conditions in clinical practice. We are trained to recognize bleeding, inflammation, pressure spikes, and complications, and to respond appropriately. I wish I could invite each of you to my practice this morning to observe what optometric surgical care looks like in practice --I want you to see that this is not hypothetical or futuristic. It is careful, measured care that benefits patients.

And through all of it, our guiding oath to patients remains the same: first, do no harm.

These are serious procedures. They deserve serious discussion. I've listened carefully to the concerns raised here, and I respect them…But I also recognize something familiar in this debate.

When optometrists first sought authority to dilate patients, the public messaging was similar — that patients would be harmed, that the education and training was insufficient, that the risks were too high. Rhode Island passed dilation authority in 1971. Maryland, the 50th state, followed in 1989. It took nearly two decades for full national adoption. Today, dilation is standard of care in optometry and ophthalmology.

The same was also said when optometrists sought pharmaceutical prescribing authority and when we obtained DEA licensure. Change is uncomfortable — especially in health care — but modernization does not equal recklessness.

It equals progress.

I chose to complete a residency in Louisiana in 2015, just after their scope modernization passed. At the time, I did not fully appreciate how significant that was. As a new grad, I simply wanted to practice comprehensive, contemporary primary eye care at the full extent of my training.

It wasn't until I attended conferences and met colleagues from other states that I realized something striking. Many of them were trained in the same procedures I was trained in. They passed the same boards. They learned the same skills. But their state law did not allow them to use them. They would express curiosity at my surgical experience — yet there was nothing unique about what I was doing. I simply lived in a state that trusted optometry's education, board certification, and licensure.

After residency, I considered moving closer to family. But I could not imagine stepping backward in the care I could provide. I stayed in Louisiana because I could practice responsibly at the level I was trained to provide. Now, more than a decade into practice, I am rooted in my community and cannot imagine leaving my patients…there's just too much trust over the years built to abandon their care.

I also share your concern about safety. I take it personally and understand the seriousness of altering tissue with a laser or on the eyelid. I respect it deeply. Every procedure I perform reflects not only on me, but on my entire profession.

However, if widespread harm were occurring in states where optometrists perform these procedures, we would see it clearly in the literature, in malpractice trends and increased rates, and in public safety alerts. We have not seen that materialize. Complication rates remain low and comparable. Malpractice premiums have not skyrocketed—even in my state-- as you can see from the documents shared since 2011, which was before Louisiana modernized its scope to where its rates are as of 2024.

As the committee is well aware, Vermont's bill includes additional coursework, preceptorship, documented competency, informed consent, and 30-day adverse event reporting. Those are significant protocols above and beyond education, board certification, and licensure. They are stronger guardrails than what Louisiana had in place when its law was regulated by our state optometry board, and tens of thousands of laser procedures safely done since.

Finally, I want to address something that struck me deeply after the last committee meeting with ophthalmology, when Senator Morely asked if ophthalmology could work with optometry on coming to an agreement on this bill, and he was told no…

While I was still a student and did not fight the legislative battle in my state, I know the debates and news articles were equally contentious. From what I've seen, the intensity of this bill only exists in legislative rooms like this one. But once the bill passes, we all go back to work, serving in our complementary and now expanded roles, and caring for our mutual patients just as we always have together.

S. 64 recognizes optometrists are trained to manage appropriate primary-level surgical care and will continue to refer when complexity exceeds that level. For Vermont, the optometrists who

acquire this additional licensure will help create a workforce better prepared for the growing eye care needs of this state — safely, with defined guardrails, and responsibly.

I am not asking you to imagine what optometry could become in Vermont.

I am speaking today as an example of what over several decades of responsible modernization already looks like:

It looks like continuity of care.

It looks like collaboration.

It looks like sound clinical judgement.

It looks like safety.

And I believe Vermont is ready for that future. Thank you.

In hope and gratitude for your time,

Amy A. Puerto, OD, FAAO
Trustee, American Optometric Association
Diplomate, American Board of Optometry
Member, American Public Health Association