



HPRAC Questionnaire Re: Eye Care Sector Issues

1) In order of priority, what do you think are the key issues facing the eye care sector?

RESPONSE:

- (i) Allowing open Collaborative Care between all eye care sectors.
- (ii) Strengthening Quality Assurance (QA) in optometry
- (iii) Reinforcing that public protection through clinical standard enforcement is the main mandate of any regulatory College
- (iv) Reinforcing that business regulation is not within the mandate of any College.

2) In your view, how can the key issues be resolved? What is your organization prepared to do to resolve them?

RESPONSE:

- (i) IRIS The Visual Group is founded on the Collaborative Care model. Ophthalmology, Optometry and Opticianry all work in a collaborative manner within our group. IRIS has two ophthalmology clinics (one in British Columbia and one in Quebec) and over 165 IRIS centres in which optometrists and opticians jointly provide patient care with each professional within the group working within their respective scopes of practice.
- (ii) IRIS The Visual Group has taken the position that the public should be provided with the best available service and products in the world of eyecare. IRIS' core values are "Passion, Honesty & Respect". All IRIS locations hold themselves to the highest standards of patient care both in terms of health care and optical devices provided. Vision depends on both of these factors thus each component is just as important. Through our collaborative model, IRIS The Visual Group is well positioned to have (in addition to College clinical standards) internal policies which elevate the standard of care internally within the group to all eyecare providers within our model. IRIS The Visual Group has the same model of care across Canada and firmly believes that this model of care, whilst certainly not the only valid model, is both in the best interests of the public and the eyecare professions as a whole.

(iii) IRIS The Visual Group has made it clear through communication to regulatory bodies (and previous legal action) that public protection through clinical regulation enforcement is their sole mandate. Those bodies have improperly focussed on business regulation, and the debate over conflict of interest and related issues (*i.e.* advertising, branding and association) has consumed far too much regulatory time and expense, to the detriment of the public. IRIS remains willing to work with all stakeholders to develop a universal and simple COI regulation for all of the health professions in the eye care sector, thus ensuring that the regulatory bodies can focus on the enforcement of reasonable and necessary practice standards to protect the public.

HPRAC note: Many of the conflicts and barriers to collaboration that have been identified in the past relate to rules and regulations regarding association of one eye care profession with another at the point of care, and limited collaboration among health Colleges in the development of regulations, standards of practice, guidelines and rules.

3) What should be the role of the health Colleges in defining and regulating appropriate business practice and business or professional association and what is the rationale for your view? How are patients and the public interest served by such rules and regulations?

RESPONSE:

The regulatory health colleges have no role whatsoever in the regulation of business practices or association. It has been conclusively determined that such regulations are enacted and enforced in the best interests of the profession itself, not the public. Reference can be had to the evidence reviewed and adopted by the British Columbia Supreme Court in *Costco Wholesale Canada Ltd. v. British Columbia Assn. of Optometrists*, [1998] B.C.J. No. 646 (“Costco”). Academic research, along with an intensive study by the U.S. Federal Trade Commission, clearly demonstrated that regulations pertaining to association, advertising and trade names did not advance the public interest and were protectionist in nature. Similar conclusions were reached by the federal Competition Bureau in their recent review of these issues; see *Self Regulating Professions: Balancing Competition and Regulation Dec 2007*. There is no evidence to suggest that the public interest cannot be adequately protected through the enforcement of universal practice standards, as is done in many other jurisdictions in North America and Europe, including British Columbia and Alberta. Simple regulations precluding false or misleading advertising, and the practice of a profession while in a conflict of interest, are all that is required. The recently enacted bylaws of the British Columbia College of Optometrists provide an excellent illustration of such an approach.



4) Please identify the basic principles that should guide any regulations regarding business practice, professional association and conflict of interest. (For instance, accountability of professional to the patient; patient access to appropriate care; obligation of professional to rebuff influences that interfere with professional judgment ...)

RESPONSE:

As above, there is no public policy justification or statutory authority for the enactment of regulations pertaining to business practices or professional association. Standards of practice which require accountability to patients, access to appropriate care etc. are all that is required. It must be acknowledged that all health professionals, regardless of mode of practice or association, are in a conflict of interest by virtue of the fact that they derive income from the services and products they provide to the public. Ensuring professionalism through the enactment and enforcement of universal standards of practice is the only acceptable approach which can be justified from a public interest perspective.

5) How could collaboration among the opticianry and optometry professions be improved through changes to regulations and standards respecting business practices and association of professions? For instance:

- i. Should there be common conflict of interest regulations for both the professions of opticianry and optometry?
- ii. Should there be common advertising regulations for both opticianry and optometry?
- iii. Should the same code of ethics govern both professions?

RESPONSE:

We believe that interprofessional collaboration is in the best interests of the patient and also follows Ministry of Health and Long Term Care (MOHLTC) published guidelines. In our view, the elimination of all regulations pertaining to business practices and association is the best way to facilitate such collaboration. It is entirely possible to have very simple regulations pertaining to advertising and conflict of interest which apply to all three eyecare professions (including

ophthalmology). Indeed, there is no reason why such regulations could not apply to all healthcare providers, not just the eyecare professions.

What other matters should be considered?

RESPONSE:

Other factors which we feel would improve the collaboration of all three eyecare providers specifically in terms of association are:

- (i) Programs / incentives to encourage all education facilities for all three eyecare groups to have components within their courses which educate their students about the role of the other health care providers. This should include physical visits to the educational facilities of the other eyecare groups.
- (ii) Programs / incentives to encourage collaborative care environments provided to the public.
- (iii) Developing a regular meeting forum within which the Ministry of Health or HPRAC can consult with representatives of each eyecare profession (as a group, not individually) to discuss the concerns of each group in an open and constructive manner.

6) What steps could be taken to ensure that, if the regulations and ethical codes are the same for the professions of optometry and opticianry, they are developed jointly; or if not the same, that they are developed through significant consultation with the other profession?

RESPONSE:

It should be stated again that any COI regulations should apply to *all* eyecare professions. That said, we believe that the following steps will ensure that any regulations formed are to the satisfaction of all providers:

- (i) All proposed regulations should be circulated to each stakeholder.
- (ii) HPRAC / MOHLTC should consider creating a forum whereby each stakeholder is represented and open discussions can be had over any issues arising.

Any stakeholder not in agreement with any regulation has an opportunity to express their views *in person* to the other parties with HPRAC / MOHLTC present.



The COI regulations do not need to be lengthy or complex so should not require extensive debate amongst the professions.

7) Should members of the eye care professions be permitted – or encouraged – to work together to provide patient care in a collaborative business partnership, corporate enterprise or professional team, or in the same setting? How can this best be accomplished? What are the benefits? What are the drawbacks? What are the standards that need to be in place to ensure that the patient is the focus of care, rather than the interests of the professionals?

RESPONSE:

It is our opinion that professionals with similar scopes of practice should be encouraged to work together. This is in line with previously published Ministry of Health Guidelines (*July 2005, MOHLTC publication: Guidelines for Drafting Conflict of Interest Regulations by Health Regulatory Colleges, Health Profession Regulatory Policy and Programs Branch*). We believe that the mode of practice is essentially irrelevant as long as clinical standards are adhered to and more importantly enforced. Of course, IRIS The Visual Group's collaborative care model is our preferred model (with the doctor being a part-owner of the practice and an independent contractor) but it must be noted that saying that one model is better over another is more opinion than fact. There is no evidence whatsoever that restricting association or advertising is beneficial to patient care. Actually, as set out above, the contrary evidence exists. When all eyecare parties have a vested / financial interest in any practice model, it is a very good model in our opinion as each professional will act in a manner that is beneficial to the practice's long term viability. The benefits of this model is that it makes good patient care much more likely as (i) the patient has access to all professions in one location and (ii) each eyecare professional may consult the other.

To ensure that the focus of any model (not just the collaborative care model, but traditional models also) is patient care in our opinion, simply requires an effective and actively enforced Quality Assurance (QA) program for each regulatory College. This alone in our opinion is all that is currently needed (and all that has ever been needed) to ensure good quality clinical care in any profession. It is

perfectly feasible for any practitioner to be unethical in *any* model of practice if he or she so chooses. Every practitioner (regardless of model) has overhead to pay. As discussed above, conflicts of interest exist for all eye care providers, not just providers within certain models. In effect, the ethics of a practitioner comes down to the practitioner, not the business arrangement they are in. Thus, the only sensible way to regulate professionalism is to have effective and stringent clinical QA within each College. Can we regulate whether a professional is going to act in his / her own benefit (rather than the benefit of the public)? This is a question that plagues every regulatory College or healthcare system. We must accept that three forces will (and should) counteract this potential issue, namely (i) market forces, *i.e.* patients will simply go somewhere else if they feel they are not getting value for money, (ii) a QA program that actively enforces clinical standards and (iii) an effective mechanism for patient complaints to be dealt with in a fair manner to all parties concerned. We believe that as long as these factors exist (especially a stringent QA process), the concern of practitioners being unethical (in any model) is negated.

8) Are there issues that need to be addressed in the sharing of patient records among professionals in a collaborative practice or among professionals who share care of a patient? Are current regulations and statutory requirements appropriate, or are changes required? How can professions collaborate in developing shared standards in the absence of electronic health records?

RESPONSE:

We believe that current regulations are appropriate in this regard. Namely that:

- (i) The practitioner remains the custodian of all health care records
- (ii) Any access to the records is by person(s) deemed appropriate by the practitioner.
- (iii) Reasonable steps are put in place to ensure confidentiality of all records.

In the collaborative care environment, all professionals should have access to the patient records and in the IRIS model the record itself remains under the official custodianship of the primary healthcare professional. This could also be agreed upon on a case by case basis within each collaborative care arrangement as long as an RHPA professional is the custodian.



9) Would the regulation of optical premises (similar to the regulation of pharmacies under the *Drug and Pharmacies Regulation Act* in Ontario or comparable to the regulation of optical premises in other jurisdictions) be in the public interest? Why or why not? What elements should be included in such legislation or regulations were it to be enacted? What is the impact on, or benefit, to the patient?

RESPONSE:

There is no public interest justification for the regulation of optical premises. By “premises” we assume the question is referring to dispensaries, which would include all types of dispensaries, including those owned and operated by traditional optometrists operating out of a single self-contained office. There is simply no risk of harm, akin to a pharmacy where dangerous or lethal pharmaceuticals are dispensed, which could possibly justify the regulation of dispensaries. This would amount to an additional layer of regulation which would serve only to drive up prices for the consumer without any demonstrated benefit of public protection

10) *A number of leaders in the eye care sector have suggested that an Eye Care Network or more formal organization, in Ontario, involving, perhaps, the health Colleges, professional associations, educators, retail corporations and suppliers would contribute to the development of all of the professions and how they work together to benefit their patients.*

i. Is this a viable option and would it add value in patient care? In professional relations? In clinical competencies? In integrating new technologies or systems? In other ways?

RESPONSE:

Unless and until the colleges of optometry and opticianry are prepared to fully embrace unrestricted interprofessional collaboration, we are not convinced that such an organization will actually be of benefit. We certainly support such an organization at a more general level, but fear it would not be able to achieve its objectives until the eye care colleges are prepared to eliminate their regulations on business practices and professional association. If such an organization were to be created, HPRAC or MOHLTC must be in charge of maintaining it so as to ensure that its focus remains clearly on two issues (i) quality of care delivered to the public and (ii) allowing practitioner's choice as to what model of practice they work in.

We do feel that the Clinical Competencies are solely in the jurisdiction of the regulatory Colleges (and should properly be their main function). Thus, any such eyecare network proposed should be focussed mainly on making sure that the eyecare industry in general has the public interest at heart whilst also allowing practitioners to practice in the clinical environment of their choice as long as clinical guidelines are upheld, without fear of professional intimidation.

In terms of professional relations and integrating new technologies, if we simply encourage collaborative care alone we feel that these two factors will naturally follow (with or without such an eyecare network). Systems become more efficient and effective in our experience when two pre-conditions are met, and it is also how IRIS makes any decision affecting its operations, namely (i) is the change in the interest of the patient? If the answer is yes, then (ii) is the change in the interests of our practice model? If the answer is yes on both counts, then we make the change. Thus, technology improvements and overall improvements in patient care quality will usually follow in a collaborative care setting.

ii. How would you see the establishment of such an organization in Ontario (e.g., a possible mandate, whether it should be voluntary or mandatory, i.e., a regulated body as occurs in some



jurisdictions). What should be the specific roles of health colleges, professional associations, educators and the retail sector; how should funding and governance be addressed?

RESPONSE:

If such an organization were to be established, we would think it vital that three main pre-requisites would have to exist to making this a body that will have any effect (in addition to the colleges being prepared to fully embrace interprofessional collaboration):

- (i) All representatives from each body must be selected by HPRAC or the MOHLTC
- (ii) The Colleges role in such a committee will be advisory only as their mandate is mainly public protection through quality assurance in the clinical care domain.
- (iii) Participation in the group is dependent on an invite by HPRAC / MOHLTC and should be mandatory.

The main role of such an eye network in our opinion, should it be formed, is to discuss options on how to provide eyecare in Ontario in a respectful manner and to encourage collaborative care models. Funding for this group should be provided by the MOHLTC and governance should be by the MOHLTC or HPRAC and no-one else.

iii. What other options could be pursued for ongoing dialogue among the professions and is an organized forum necessary?

RESPONSE:

This response ties into our response for Questions #5 and #6. We agree that a forum should be formed with equal representation by all stakeholders. Regular (HPRAC supervised) meetings should be held to discuss any ongoing COI or inter-professional issues. It is also arguable that HPRAC should be given some enforcement powers in terms of College by-law legislation as currently HPRAC is solely an advisory body. This forum will in our opinion help to serve the following issues:

- (i) Any issues are discussed and dealt with in an open forum thereby preventing them from becoming larger interprofessional issues down the line.
- (ii) HPRAC gets to hear all sides of an issue in an efficient manner.
- (iii) HPRAC can ensure that public protection is at the centre of every discussion and not the vested interests of any of the parties concerned.
- (iv) Giving HPRAC the power to intervene with College by-laws ensures that regulatory Colleges will create by-laws that are fair to both the public and each profession.



11) *Opticianry, optometry and medicine (general practice and ophthalmology) are all regulated health care professions in Ontario, each with differing – and sometimes overlapping - scopes of practice. Historical and cultural differences among the professions, often having little to do with delivering optimal patient care, have resulted in long-standing antipathies and misunderstandings between or among these professions and their regulators.*

i. How can respect among the three professions best be fostered, and what opportunities need to be provided so that each of the professions understands and appreciates the skills, knowledge and qualifications of the other, and is able to work in a trusting, collaborative relationship with members of other professions?

RESPONSE:

Respect between the different professions can be fostered in our opinion by HPRAC, the MOHLTC and each regulatory College all doing the following:

- (i) Openly and actively encouraging collaborative care
- (ii) Require all training institutions for each eyecare profession to have a minimum amount of “contact time” with the other professions. This may take the form of interprofessional lectures, seminars or visits to the training locations of the other profession.
- (iii) Allowing optometrists to enter into hospital practice arrangements. This is currently virtually non-existent in Ontario hospitals and given that Optometry is soon to be TPA certified, makes sense in reducing hospital wait times for eye related issues.
- (iv) Removing all restrictions on association between the three eyecare professions.

ii. To what extent does this already occur?

RESPONSE:

In our opinion, none of the above factors currently occur in Ontario. For example, it is still technically an act of professional misconduct for an optometrist in Ontario to hire a licensed optician to dispense prescriptions to patients. There is very little (if any) collaboration between the three eyecare training institutions and certainly optometrists find it very difficult (if not impossible) to enter into hospital based practice. There is no open encouragement from what we can see by any eyecare body apart from IRIS for collaborative care. The Ministry of Health has made it clear through its mandate that they are encouraging collaborative care models. Thus, having restrictions still in force in Ontario seems quite illogical and is frankly detrimental to the public interest.

iii. What is the role of joint entry-to-practice education and joint continuing education in enhancing such understanding? Is public education required?

RESPONSE:

Joint continuing education (CE) is useful to a point in educating each eyecare group about what the strengths of the other professions are. However, CE tailored to each group for each group is still essential for content relevance and should not be replaced solely with “collaborative CE”. Each profession has internal CE requirements that they themselves best understand. That said however, we completely agree that the public needs to better understand the differences between the professions which is again why collaborative care models have such strength. The public has access to each eyecare professional in one setting and gets the best from each eyecare professional within their scope in that one setting. Thus, the patient has now (i) received the best care from each professional and (ii) now understands the difference between the roles of each professional. This again highlights why the MOHLTC has endorsed and IRIS supports collaborative care.



iv. Would joint health College professional development and continuing competence programs be useful in engendering trust and respectful working relationships? How can joint professional clinical experience, through clinical practice requirements, externships and other mechanisms at the educational level be introduced or enhanced? What steps have been taken to date to do so?

RESPONSE:

Joint professional development may be useful in the regulatory College settings to encourage trust and respect but it is IRIS' position that the regulatory Colleges should not be merged. Having regular professional development through joint panels supervised by HPRAC for example would certainly be productive. It may be also be useful to have mandatory annual presentations by each College to the other respective Colleges to update them on their respect roles and how they are enforcing their own QA standards internally.

Speaking in terms of the training institutions (or health Colleges as the question was termed, *i.e.* School of Optometry, School of Opticianry and Ophthalmology residencies), certainly having portions of the training being mandated to be "interprofessional" is a sensible approach. This is already being done at the Schools of Optometry in Montreal and in Waterloo where student optometrists have licensed opticians on staff to work with. This is a facet of eyecare that should be encouraged and fostered.

Joint professional endeavours at the educational level could be introduced by encouraging the following at each educational establishment for the respective eyecare profession:

- (i) Mandatory minimal amount of "contact" with the other two eyecare groups in their respective training environment.
- (ii) Actively encouraging mutually beneficial guest lectures by each eyecare provider group and providing MOHLTC funding to encourage this.

12) Please cite examples of successful interprofessional collaboration among eye care professions (including family physicians and general practitioners), educators or regulatory organizations that have occurred or are occurring to date. For any unsuccessful projects undertaken within the past five years, please briefly describe them and explain why they failed.

RESPONSE:

Examples of successful interprofessional collaboration in Ontario:

- (i) IRIS The Visual Group (Ophthalmology, Optometry and Opticianry). Optometrists regularly present to opticians and vice-versa. Ophthalmology regularly has CE days at their surgical sites for both optometrists and opticians.
- (ii) Victoria School of Optometry (Family Physicians and Optometry)
- (iii) Despite current optometric regulations prohibiting interprofessional collaboration between opticians and optometrists, there exist many private optometric practices that employ licensed opticians, and have done so for many years. Due to selective enforcement of these regulations by the college of optometrists in Ontario, these collaborations have not been openly communicated to the public for fear of reprisal.

We are not aware of any “unsuccessful” interprofessional collaboration among eye care professionals.



13) *In HPRAC's recent interviews, we heard that each eye care profession should practise to its highest level of competence, and this should be a continuing evolution, with each profession, within its scope of practice and under its controlled acts, taking on roles that reflect its members' growing knowledge, skills and judgment. We live in a society that is characterized by demographic change: an aging population, increased incidence of diseases or conditions that might impact eye health, and that these health care matters need to be addressed, in a co-ordinated way, by eye care professionals.*

i. How can the three professions work together to recognize this demographic change, to incorporate new proficiencies, accountabilities and skills of members of each profession so they are recognized and applied to patient care and to address increasing demand for appropriate eye healthcare?

RESPONSE:

The three professions can work together to recognize the demographic change by realizing that collaborative care is the way forward. Each profession has its strengths (and weaknesses) but harnessed together can be an invaluable tool in dealing with an aging population. The answer here is that by simply allowing and actively encouraging collaborative care (and the corresponding elimination of regulations which restrict business practices or association), the MOHLTC, HPRAC and the various Colleges can aid in forming an eyecare framework that works for both the public and the eyecare providers themselves. The three professions can also make a real effort to understand the training and the sensible scope of practice of each other and more importantly how their scopes can best be integrated to provide the public with the best care possible.

ii. How confident are you, or members of your profession, about the clinical knowledge, skills and judgment of other professions that provide eye care to meet patient care needs? What needs to improve, and how can it be improved? What new information do you need to comprehend the roles and qualifications of eye care colleagues?

RESPONSE:

Optometry (the majority group within IRIS) is confident about the skills of both opticianry and ophthalmology within their scopes of practice and areas of expertise within our group. For example, opticians are perfectly competent at dispensing prescriptions and identifying the visual needs based on an optical prescription from an optometrist or physician. They are also very competent at problem solving in cases where a patient may not be adapting to a new prescription for example. Optometry, being the main point of contact for ocular health assessments (*i.e.* retinal examinations for glaucoma and macular degeneration for example) is often the point of first contact for the public in terms of eyecare. IRIS believes that optometry as a whole are in a good position to judge how opticianry and ophthalmology should be integrated with optometry for the overall benefit of the patient as optometrists have significant scope overlap with both opticianry and ophthalmology.

In terms of improvements, we believe that the lack of collaborative care models between all three eyecare professionals is the single biggest barrier to improving the abilities of all three professions. Solving this simple issue we believe will go a long way towards helping each profession really understand what the other does and what they bring to eyecare. That said however, each profession must respect the scope of the other professions and only practice within their approved scope as determined by HPRAC and the MOHLTC (*i.e.* the RHPA Act). Each College (i) actively enforcing their QA regulations and scope and (ii) not having any barriers to interprofessional collaboration, would go a long way towards allowing the eyecare professions to trust each other and focus on patient care issues.



iii. Do you see evolving roles (e.g. optometrists accepting, with appropriate training and skills, more responsibility for medical therapeutics) as a benefit for the patient, or as a matter that impacts financial sustainability for other professions? Can enhanced scopes of practice for some professions offer advantages for others in increased time and opportunity to care for patients with increased morbidity and complexity? How can competing professional interests be balanced in favour of the patient?

RESPONSE:

Increasing scope of professions is appropriate when (i) the public is not put at risk in any way and (ii) the profession achieving the increased scope has demonstrated the training and education to warrant the increase in scope. The issue of “competing professionals” is again negated by encouraging a collaborative care environment focused on quality patient care. The increased scope for optometry for example in terms of therapeutics is an excellent example of how ophthalmology can be freed up to see more complex surgical cases. There is no real “competing interest” in this regard as ophthalmologists have plenty of patients that require care. In terms of opticians refracting however, there is certainly a competing interest here as both optometrists and opticians sell optical appliances and derive a moderate proportion of their income from this activity. Given that refraction alone does not in any way rule out serious ocular disease, it is not sensible to allow refraction as a stand-alone service by any professional eyecare group (including family physicians, not just opticianry). It does make perfect sense however to have a collaborative care model whereby opticians and optometrists should be encouraged to work together for the mutual benefit of the public and share in the financial rewards of optical retailing. Collaborative care centres can then use these rewards to better improve the quality of care delivered to our aging population.

14) What does your organization’s ideal eye care world look like?

RESPONSE:

Our organization wishes for an eye care world made of up of diverse groups of eye care professionals working in open collaboration under different banner names or brands. IRIS has what we believe to be the ideal eyecare model based on the following desirable factors:

- (i) Collaborative care (ophthalmology, optometry and opticianry working together)
- (ii) High quality care environment (both in terms of professional service and products)
- (iii) Entrance and exit strategy for professionals that is financially viable
- (iv) Canadian owned corporate component with the RHPA professional being an equal partner.
- (v) Health professional remains the custodian of the health records.
- (vi) IRIS The Visual Group takes care of management logistics thereby allowing the health professional to focus on their job – looking after the public.
- (vii) The health professional shares in the rewards of a successfully run practice.

15) Are there other issues that you would like to raise for HPRAC's consideration? Please describe.

There are no other issues we would like to raise at this time.