



**The Ontario College of Family Physician's
Response to
The Health Professions Regulatory Advisory Council's
Questionnaire on Eye Care Sector Matters**

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Introduction:

The Ontario College of Family Physicians (OCFP) was pleased to have been asked to respond to a series of questions on the issues that are facing our healthcare system in the delivery of eye care. Members of our Board responded to the questions and their direct quotes are included to help illustrate the problems they face in trying to access care for their own patients. The OCFP is pleased to assist with this process and anxious to participate in the next phase of implementing recommended solutions.

Answering the Questionnaire:

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

The key issues facing the eye care sector, according to the members of the OCFP Board are as follows:

- **Lack of access to ophthalmologists**

“In our community, access to non-surgical eye care, even if emergent, is exceptionally difficult to access. This means that most patients have to be sent to an emergency department with the hope that the ophthalmologist-on-call will see them. It is because most ophthalmologists have limited their practices to narrow scope of field of specializations such as cataract surgery. Even if they have seen the patient in the past for the same problem, they refuse to see the patient and advise me to send the patient to the ED. The conditions that I need help with need to be seen same day (painful red-eye, history of a retinal tear, acute or semi-acute neuro-ophthalmology condition, herpetic infection, foreign body in the eye, an irritated eye that is not responding to the usual treatment and other situations where a slit lamp exam is needed. Regular appointments, even if accepted, are usually given several months away.”

“The major problem that I am encountering is getting access to medical care for eye problems. The fees for cataracts skew care so the ophthalmologists are reluctant to spend their time taking care of glaucoma or any other eye problem unless it requires a surgical treatment. There are a few medical ophthalmologists but the way the fee increases have been applied to surgical treatments instead of medical treatments affects access to care. The private fees associated with refractive surgery are another area of diversion of effort from publically funded health care.”

“Ophthalmologists just want to operate and not many of them are really keen to do primary eye care and medical ophthalmology.”

“Paediatric ophthalmologists are especially scarce and wait-times are long, especially for patients with chronic eye conditions, strabismus and other conditions. Parents suffer needless during this wait period and we miss opportunities for early interventions.”

- **Lack of confidence in optometrists**

“I have started to use optometrists but I have no reassurance that their skill sets are optimum and I do not understand their scope of practice. Clarification on their level of training/scope of practice/quality assurance program would be helpful.”

“Optometrists, from time to time, contact family physicians requesting that they prescribe medication for patients seen and diagnosed by the optometrists but family physicians are unable to confirm the diagnosis; therefore, should not be prescribing the medications and the patient loses out on immediate access to care.”

“Diabetes guidelines require regular eye examinations. They are not urgent and the patients can be put on the wait-list to be seen; however, adherence to guidance is compromised by the lack of access to eye care for prevention. Optometrists could probably perform these exams but I lack confidence in their skills”.

- **Conflict of Interest**

“The Conflict of Interest needs to be addressed when optometrists conduct eye examinations and then sell eyeglasses/contacts. This is also true of some ophthalmologists and in the private sector when they advise refractory surgery instead of glasses.”

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

- Ophthalmologists have been incented to provide cataract surgery and private sector refractory surgery is very lucrative. The provision of incentives for ophthalmologists to provide emergent care to relieve pressures on emergency departments should be considered. The fees for surgical procedures could be frozen to allow any negotiated fee increases to be applied to the medical fee codes; however, it is difficult to address the amount of time spent in the private sector undertaking refractive surgery.
- Consider the development a medical ophthalmology residency program. Most of the training for ophthalmology is surgical and a resident could be trained in a year to provide most of the medical aspects of ophthalmology and primary eye care.
- Provide workshops for family physicians and emergency physicians on the diagnosis and treatment of common eye problems including the proper use of slit lamps.
- Developing a mentoring/shared-care program that links ophthalmologists, optometrists and family physicians in communities to jointly address eye care needs in communities. This model is working well in some communities so the pilots have already been undertaken.

- Allow limited prescribing powers for optometrists who are part of a shared-care/collaborative care network with ophthalmologists and family physicians.
- Ensure that optometrists are well-trained, take part in ongoing quality improvement/assessment programs and ensure that other providers are aware of their scope of practice/training/capabilities.

Our College would be pleased to develop an educational program for family physicians; use our expertise to set up a shared-care, mentoring pilot program and work with optometrists/ophthalmologists to increase awareness of scope-of-practice/training/capabilities of both professions.

“I am finding that there are examples of collaboration between optometry and ophthalmology in Northwestern Ontario. In rural Ontario, we cannot support and ophthalmologist so a lot of optometrists have a good working relationship with eye surgeons in larger communities. This frees up the ophthalmologist from some of the routine office-based eye care and prevents unnecessary travel fro our residents”.

- 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?**

The public looks to the professions to self-regulate, in both clinical and business practices. Rules and regulations provide clarity to the professionals so that they are functioning in the same way as their peers and to the public by addressing issues such as conflict of interest.

- 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.)**

The overriding principle of the healthcare system is **equity** – the most care delivered to those in most need (i.e. emergent care should take precedence over routine care or non-medically essential services).

The second principle is that the service provided should be **patient-centred** (i.e. the patient's needs, rather than provider benefits, should come first). No-one should directly benefit from a referral to another eye care provider or from the ability to diagnosis and order the treatment. There is a perceived conflict when the eye care provider recommends a prescription and then dispenses the prescription.

“The purest relationship occurs when the eye care prescriber sends the patient to an independent optician. In rural communities, this may not be possible. We also see a conflict of interest when ophthalmologists prescribe corneal refractive surgery when glasses may have been just as good and safer.”

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?**

What other matters should be considered?

The principle that was established in medicine should be in place for all professions – the diagnosis and development of a treatment plan should be separate from the dispensing/selling function (i.e. physicians are not allowed to dispense drugs; pharmacists who diagnose and order medications should not be allowed to dispense them; optometrists who examine eyes and diagnose a condition requiring drugs, glasses or lenses should not be allowed to dispense/sell them).

“Some opticians have optometrists in their place of business. A customer is referred to the optometrist to get the prescription and then the customer gets their glasses in the same office. The fee schedule is intended to cover clinical services and overhead. Ideally, this permits the optometrist to have their own office space and the customer would then be able to take their Rx anywhere. The ethics should be similar for every profession with some exceptions required in the rural, remote communities where there is a lack of alternatives”.

“Despite what is said, there is a lot of money to be made by prescribing and subsequently, dispensing glasses. I, sometimes, wonder if there are delays in referrals for cataract surgery so that a few more changes of lens can happen!!.”

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?**

They should be developed jointly and in conjunction with their medical counterparts in ophthalmology and family medicine.

“Not sure why there is no mention of ophthalmology in this question and how successful you would be in getting the two groups to agree upon a code of ethics re prescribing and dispensing without ophthalmology at the table that works with both groups and may be in the best position to help identify some of the issues including their own conflict of interest issues.”

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?

This would be the ideal (see question 2). Conflict of interest issues would be difficult to address in partnership model between optometry/opticianry.

“Optometrists and opticians are independent business people and I have a hard time seeing them in a mutual business relationship. What I am led to believe is that the fee schedule is inadequate to attract people to optometry if they are not allowed to dispense lenses. Opticians seem to work for large corporations, such as Lenscrafters as employees and do not seem to be as independent as optometry.

- 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?**

Common sense should rule. In a shared-care/collaborative relationship, information should be shared as required. The referral/consultation report works well and could continue to be the method of communication between the professions. That way any information pertinent to the eye care problem is shared.

- 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 regulation were it to be enacted? What is the impact on, or benefit, to the patient?***

Regulation would ensure inspections to review equipment and adherence to care standards.

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

This is a viable option. The OCFP is a leader in the province and across Canada in developing Collaborative Care Networks that are transforming the referral method of interaction between professionals into a consultative referral, decreasing the time interval and definitive treatment, decreasing pressures on specialist/emergency departments and decreasing costs (see Question 2).

“A utopia would be a partnership (small p) of optometrists doing primary eye care, opticians dispensing glasses economically to customers and ophthalmologists being the consultant to the previous two eye care providers. If they shared the premises and the equipment, their overhead should be minimized and there might be benefits for each one of them. In out town, all three optometrists have expensive equipment when the reality is that only one of those expensive retinal cameras is needed for the whole population.”

- 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?**
 - ii. **To what extent does this already occur?**
 - iii. **What is the role of joint entry-to-practice education and joint continuing education in enhancing such understanding? Is public education required?**
 - 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?**

In many communities, wise practitioners have found ways to work well together. It is time for professional colleges and associations to start working together in the best interest of patient care and to support their members as they struggle in this regard. Joint meetings to discuss issues in an open and frank way need to occur and may be facilitated through this process. Faculty at the colleges and universities should be supported to have interprofessional learning opportunities

and continuing professional development programs should be developed jointly to help all eye care professionals learning to appreciate one another's skill sets.

“The rural situation is likely different. We have only family doctors and optometrists. One of the family physicians has a bit of skill regarding eye care and often gets referral from the optometrists for acute eye problems. Most of the optometrists have developed a shared care strategy for our diabetic patients and those with glaucoma that usually need the ongoing expertise of an ophthalmologist. The “eye van” provides a valuable service but if it had ophthalmologists in the region on board so we could build relationships, it would be more helpful.”

- 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.**

A successful collaborative practice model between family physicians in Huntsville and optometrists occurred as a result of the OCFP meeting with the College of Optometrists and helping the Huntsville family physicians to better understand the skill sets/equipment available locally; thereby reducing referrals to ophthalmologists practicing at a distance from the town significantly.

“This is a tricky area that needs a patient focus. The lack of competition in some communities with opticians means that patients usually pay more for their glasses and lenses. Too much collaboration may have an unexpected consequence that needs to be carefully managed.”

- 13) **In HPRAC's recent interviews, we heard that each eye care profession should practice 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-ordinate 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?**
 - 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?**

- 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?**

Family physicians and their patients require that the three professionals find ways to work collaboratively together. With aging patient populations more care, not less, will be needed. The current system is not working and issues need to be addressed.

- 14) What does your organization's ideal eye care world look like?**

Patients receive timely and effective eye care from coordinated eye care networks at the local, regional and provincial levels.

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

The Ontario College of Family Physicians recognizes that the main providers of eye care in the province need to find a way to develop effective system and educational processes to better serve the population. We are only too willing to work with ophthalmologists, optometrists and opticians to address the needed changes in the system.