## Canadian Optometric Education Trust Fund[1]

# Part III:
# The Medical Threat to Scope of Practice[2]

**This is a continuation of our series outling the practical and urgent needs your Trust Fund is attempting to meet.**

The medical profession as represented by the Canadian Ophthalmological Society has considered its future role in the delivery of vision care service. They have developed a program in response to their evaluation and have since 1975 implemented an action program to achieve their goals. Within this section of our Trust Fund discussion paper we will outline their program in terms of how it affects the profession of optometry and how it could potentially prevent us from attaining our own future scope of practice goals as outlined in Part I of this series of articles.

### 1. Understanding Ophthalmology's Program

Canadian optometry has developed an accurate overview of the concerns of ophthalmology from an address made by the former Executive Director of the COS in 1976 to an American state association of Ophthalmologists.(1) We have paraphrased important sections of the address and identified their plan of action to expand the scope of practice of ophthalmology:

a) The central issue surrounding the future of the medical practitioners involvement in the delivery of vision care services:

> *". . .Will optometry and all of the other non-medical health groups be permitted to practice medicine: and will they be permitted to displace physicans from any part of the practice of medicine?"*

b) The defensive steps that the COS is taking to prevent optometry's continued involvement in all aspects of primary care indicates that they will carefully monitor developments on four fronts:

1) They will watch health disciplines legislation such as the Optometry and Medical Acts which determine roles and scope of practice.
2) They will watch health delivery legislation such as medicare and health insurance programs which can affect roles and scope of practice in ways they might not always suspect.
3) They will monitor and seek to participate in all attempts at health manpower planning, since views about future roles and scope of practice often surface first in such planning.
4) They will pay special heed to health budgeting analyses, for many of the government's plans in regard to future roles and scope of practice are bound to derive from this source.

c) The steps the COS will take as part of their own action program to put them on the offense regarding optometry's growth indicates that:

1) They will plan long-term and future roles for ophthalmology and for all other potentially useful eye-care personnel, including optometrists in a manner that may or may not be similar to present roles. They may decide that, in the future, ophthalmologists should continue to do over half the primary eye examinations — or that they should reduce the proportion and concentrate more on secondary and tertiary care.
2) They will then develop positive plans based on their role models and attempt to seize the initiative for the first time and set about selling their positive plans as being preferable to others.
3) Having established their policies and objectives, they will pursue them consistently in future approaches to health discipline legislation, health delivery legislation, manpower, and health budgeting — as well as in other areas of activity.

### 2. Ophthalmology's Program in action

Based on our understanding of the objectives associated with ophthalmology's action program to deal with optometry's continued involvement in primary care, we can now evaluate the degree to which they have pursued their stated goals in the past four year period.

a) *CNIB—Vision Canada*

A submission by the COS to the 1975-76 Unmet Needs Study of Blind Canadians was contained in the CNIB report entitled "Vision Canada" published in 1976.(2) By reviewing the following four recommendations a major change can be identified in the COS's traditional position on the scope of ophthalmological practice. They are now saying publicly that they want to be associated with *all primary vision care needs of the public* and not just secondary and tertiary care. In short, they are not reluctant to promote the image of the ophthalmologist as being an optometrist with added medical training.

Recommendation 1: Expanded Ophthalmological Services - Programs of extended service into the community by ophthalmologists (glaucoma surveys, pre-school vision screening, vision screening in geriatric facilities and similar activities) should be encouraged and expanded. Ophthalmology residents should obtain improved education in these areas.

Recommendation 3: Patient access — The public must continue to have direct access to ophthalmologists for provision of regular preventive ophthalmic care.

Recommendation 8: Delineation of Responsibilities — All practitioners with patient contact in the eye care field should have their responsibilities defined accurately in the public interest.

Recommendation 15: Low Vision Aids — Education of ophthalmol-

1 Please see last two issues for Parts I and II.
2 By Donald Schaefer, Trust Fund General Manager.

ogy residents in the use of low vision aids should be enlarged and low vision aid clinics should be established in all University Departments of Ophthalmology, where they do not now exist.

b) *Diagnostic Use of Drugs*

Preventing the use of diagnostic drugs by optometry has been, and will continue to be, a major program objective of ophthalmology. We can measure the importance they associate with this goal by the statements made within their position papers and briefs at the time of legislative hearings on this topic. In 1974 they launched their first attempt in Ontario, in 1977 we dealt with them in Newfoundland, and in 1978 New Brunswick was the scene of their latest unsuccessful challenge to the diagnostic drug provisions. But their most blatant and potentially devastating blow was launched in 1977 through their brief to the Food and Drug Directorate of Health and Welfare Canada.[3] Their objective as summarized in their brief was to demonstrate that:

*Self-medication is a danger both to vision and health. Drugs such as mydriatics and cycloplegics, local anesthetics and the powerful anti-glaucoma remedies all have serious ocular and systemic side effects. We believe that for the protection of the vision and health of the public these drugs should only be prescribed by physicians.*

If the Food and Drug Directorate had not thoroughly investigated the clinical and scientific evidence associated with the COS claim, the ophthalmic drugs could have been placed on Schedule F. As a result, provincial governments when assessing optometry's request to gain legislative provision for the use of these drugs would most certainly have regarded the Drug Directorate's decision as a legitimate argument to be applied against our request. The Directorate ruled against the COS brief following submission of a CAO brief and subsequent investigation.

c) *Medical Manpower*

In 1975 a report outlining the future requirements in Canada for physicians by medical specialty was developed in collaboration with Health and Welfare Canada.[4] From the position taken by the COS in the report we learned that:

1) Two items of COS policy with manpower implications were repeatedly stressed. The first concerns the desire of ophthalmologists to continue to undertake primary care as "it is essential to the public welfare that ophthalmologists not be excluded from primary eye care (including primary optical care)." The second policy stressed restriction of optometrists to primary optical care and the establishment of guidelines for the mandatory referral of certain types of problems.
2) The proper role of the discipline of optometry, as well as the roles of related medical and non-medical disciplines, were outlined more definitively than is the case with most other specialities.
3) Early drafts of the report indicated that the working party had been unable to reach an estimate of manpower requirements by any approach. Part of the difficulty at that time was caused by a desire to consider requirements

*(cont'd.)*

for enough ophthalmologists to provide for all eye services, however minor. The use of utilization data as an indication of who in fact had provided the specified eye services during a defined base period was ignored.

The above points should leave no mistake in anyone's mind as to ophthalmology's intent: to systematically reduce optometry's present and future influence in all aspects of primary vision and eye care service delivery.

We have itemized the Trust Fund's concerns for optometry's continued growth and development by emphasizing that the medical profession is now attempting to limit optometry's role while expanding its own scope of practice. But we obviously share a similar goal of meeting the primary vision care needs of the public. The most obvious differences between our profession and ophthalmology is that the COS has failed to grasp the reality of provincial legislation establishing the mutual right of both professions to delivery primary care to the Canadian public. The COS has also established its objectives without any practical considerations for the higher cost of training of, and service delivery by, the ophthalmologist.

We therefore remain confident that the profession of optometry, with the long-term support of the Canadian Optometric Education Trust Fund, will be prepared to meet the medical challenge to our scope of practice. The money that you pledge to the Trust Fund will mean more and better educational personnel and facilities for optometry. This is of crucial importance for it means the education of more and more optometrists with the academic and clinical skills required to freely and responsibly meet the full range of the Canadian public's primary vision care needs.

**References**


1. Nason, G. "A Chill Wind May Blow Down from Canada," Address to the Annual Meeting of the Massachusetts Ophthalmological Society. Reprints distributed by the American Ophthalmological Society. (Undated, probably 1975.)
2. Greenland, C. Vision Canada, Vol. 1, The Unmet Needs of Canadians. Canadian National Institute for the Blind, 1976.
3. A Brief Outlining the Need to Place Certain Ophthalmic Drugs on Schedule F to Be Available Only on Prescription. Canadian Ophthalmological Society, May, 1977.
4. Report of the Requirements Committee to the National Committee on Physician Manpower. Department of Health and Welfare, Health Programs Branch, 1975.


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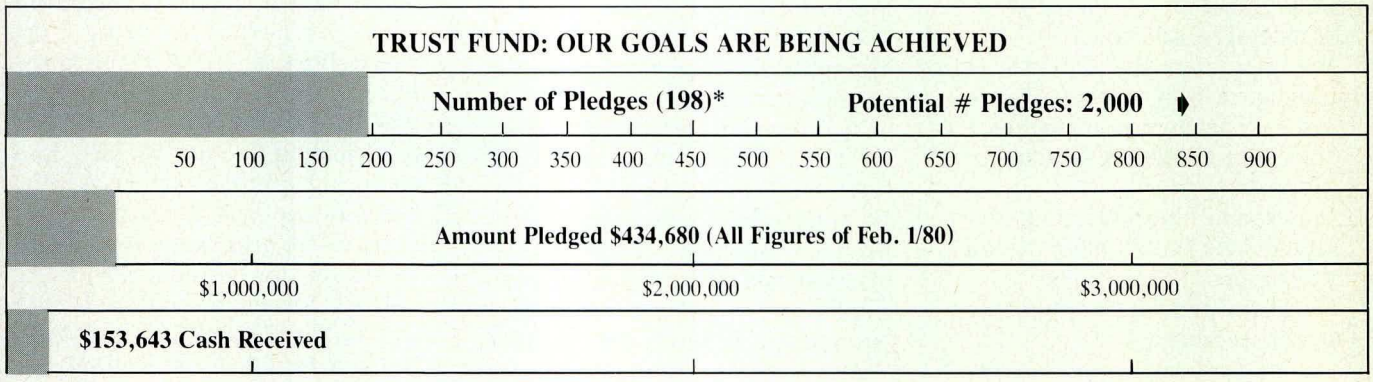


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**AUSTRALIA LOSES EXECUTIVE DIRECTOR**

Dr. Damien Smith has announced his resignation as National Executive Director of the Australian Optometrical Association (AOA) to return to private practice. He was appointed in December 1972, and during his period of office, optometry in Australia made unprecedented political and professional gains.

Announcing Dr. Smith's resignation to AOA membership, National President William H. Ure said: "Damien Smith has guided the Association past its greatest threats to its greatest political and professional advancements. He leaves a profession more prosperous and more prestigious than when he commenced in office, and a profession now firmly entrenched in the mainstream of Australia's health-care system".

Although the inclusion of optometric services under universal health insurance and the introduction of optometric care to Veteran's Affairs patients were the most notable political achievements, progress has been made by: expansion of clinical horizons and the acceptance of wider responsibilities for health of patients; access and frank communication with government; creation of an authoritative public image for optometry and a sound working relationship with the media; award of respect from all of the health profes-

*(cont'd on p. 52)*