

## CJO INTERVIEW:

### Optometry in Canada – A Review of the Seventies and a Forecast for the Eighties



Dr. Jack Huber



Dr. Roy Brown

*At the time of the preparation of this hallmark edition of the Canadian Journal of Optometry – A Review of the Seventies – CJO's Editor Maurice Belanger and Associate Editor Joseph Mittelman invited CAO President Dr. Jack Huber and Past-President Dr. Roy Brown to meet and exchange views with CAO Executive Director Mr. Don Schaefer on the major trends which have influenced the profession of optometry during the last decade.*

*In their wide-ranging discussions they dealt with many issues, the most important of which were the influences of government and medicine and the implications of consumerism for the practice of optometry in Canada.*

*Other areas receiving attention were the evolution of optometry in the field of practitioner training and the matter of specialization in optometric practise. We are pleased to present our readers with a brief summary of their remarks as they fielded the questions posed by CJO's Editors.*

**CJO:** Two factors have affected the mode of optometry in the past decade and will continue to do so in the future. One is medicine which has dominated the health care field and the other is government. How did you see their roles in the 1970's?

**Dr. Brown:** Well I think there has been a real shift in their roles. Granted, for many years medicine did dominate the health care field and the delivery of health care. But with the advent of national health care schemes and with the provinces participating in them, government has played a much greater role and will continue to play an even greater role since government is paying the bills and naturally will be much more concerned where the dollars are going and whether it is getting a true value for the money that is being spent. So I can see a much heavier influence coming from both federal and provincial governments.

**CJO:** Do you feel that the cooperation of medicine in a health plan is an essential factor to a well balanced health care service in Canada?

**Dr. Brown:** Certainly. But I think we must remember that out of every 100 practitioners in the health care field there are 87 (roughly) in fields other than physicians. So we should count dentists, nurses, optometrists, druggists, physiotherapists, the whole gamut in fact. While it was unbalanced before, the balance is beginning to come about now because the economic delivery of health care is better understood. Formerly medicine was playing its traditional role but now I think that medicine will have to accept the fact that it is only a part of the modern health care scheme and not the whole health care scheme.

When this is fully understood by medicine and health care planners there will be a much more efficient delivery of health care to Canadians.

**CJO:** Dr. Brown mentioned 87 of 100 are not physicians. How does this affect health care delivery?

**Mr. Schaefer:** I think that what we have to bear in mind is that all health care is not medical care. If you look at the one national payment pro-



gram that we have under the federal government's Health Service Commission Act it is related to payment for services provided by the physician. The trend which has been developing in the 70's as evidenced in the submissions to the recent Hall Commission Inquiry is that service should be paid for in terms of the person's qualification to render the service rather than their status as a medical practitioner. This is a vital change and hopefully in the 1980's the services of optometry, podiatry, chiropractors, the so called fringe groups or allied groups, will be recognized because they are cost efficient, they are accessible and more importantly the quality of service is as good as that provided by physicians. So health care is not medical care and if the payment mechanism relates to the provision of care in terms of the practitioner qualified rather than just medical specialist there is going to be a major change in the eighties.

**Dr. Brown:** I think you can confirm what Don has said by taking a look at the seven provinces that are included in health care schemes across Canada. The only place where they receive payment is where there is an overlap of optometry and ophthalmology and/or medicine. And now we're finding that even this is changing. For example, in Quebec you have a range of diagnostic services that are covered for payment, possibly the broadest in Canada. And certainly all the other provinces' benefits have also been gradually expanded to include more of the diagnostic roles. Someday it will include the whole range of those professions' services. And it will happen because of three fundamental reasons: first is economics, second is quality care, and a third, that the geographic and demographic distribution of those practitioners better meets the needs of the population.

**CJO:** Health care in Canada and the proposal for instituting a plan came mainly from the proposals of health care administrators; they had a very

restricted concept of health care, that health care was solely medical care. Is this not a true statement of fact? Can you relate how the changeover came about?

**Dr. Huber:** I think the term medical care traditionally comes from the longstanding domination of health by the medical profession. However, in recent years other personnel within the health care field have become much more vociferous in their demands for autonomy and optometry is one of these allied health professions. I think that government has been educated to realize that health care is not limited to medical care.

Consequently most provinces have now assumed the title of Health Care Insurance Commission for their insurance boards. This I think is significant in the fact that they realize this change in concept.

**CJO:** Do you see this trend continuing in the future?

**Dr. Brown:** I would think there would be no doubt about this. The fact is that where we have governments paying the bill, we have an economic incentive; they find that prevention is far cheaper and provides a better quality of health care than catastrophic care does. And this is what medicine was usually doing, providing catastrophic care. So groups like the Canadian Public Health Association and different public health care associations across the country are now playing a much firmer role in the prevention area.

**Mr. Schaefer:** I think the interesting part is in the early 1970's when optometry came into the programs as an extra benefit. This simply meant that not one federal dollar was going to this extra benefit called vision care. But the provinces offered it because the population wanted vision care. They have demanded its inclusion within their system. If we review what has happened within the last seven or eight years we will see that we started out by having the western provinces, Ontario, Quebec and Nova Scotia in the health care system, and they started by having

visual analysis or a refraction covered. Over the years partial assessments and reassessments are introduced. In Quebec, the complete range of diagnostic services are covered whereas in the other provinces we have varying degrees. But, you can see that as the services of optometrists are offered and as they are being accepted by the public, their demands for our services grows and grows. If you look at the 1980's I cannot see this trend slowing down. The objective of every provincial optometric association is to have visual training or contact lenses therapy also offered as a covered service. That is in response to the demands of the people you are servicing. So the 1980's look pretty good for optometry from that point of view.

**CJO:** Can you describe how the relationship between optometry and ophthalmology has evolved in the 1970's and what do you think of the outlook in the 1980's?

**Dr. Brown:** In 1971 CAO began a series of meetings with the Canadian Ophthalmological Society which were chaired by the Canadian Medical Association on all occasions. It was brought about by the fact that ophthalmology had written a statement on eye care for Canadians and wanted it published and accepted by the Canadian Medical Association. C.M.A. in turn turned it over to the Canadian Association of Optometrists to accept or to alter. These meetings weren't always easy but out of those sessions came a statement on vision and eye care for Canadians, one by optometry and one by ophthalmology which still stand today. Also the Role of the Optometrist in Health Care Delivery was developed and remains a very important document to Canadian optometry. The meetings certainly helped us to define where we were, where we came from and where we were trying to go. I think that it brought us to the point where we could see some common relationships between our two professions. And for the 1980's, I can now see a much closer working relationship between ophthalmology and op-



tometry. First of all when one takes a good look at the vision and eye care field, we find that in the North American continent roughly 92 per cent of the people are bothered by a vision problem. We have minor eye problems, 5 per cent of which are commonly administered to by the general practitioner or the family practitioner and we have 3 per cent of this total area that falls under the classification of surgery or pathology which are in the ophthalmological field. Governments have begun to take a real look at the education and future production of optometrists and ophthalmologists. This has made both of the professions and the government more aware of the manpower situation, an awareness of which will lead to a more balanced manpower situation and better vision and eye care at lesser costs to the taxpayer.

**Dr. Huber:** I wish I could be as optimistic as Roy. The Canadian Association of Optometrists was the initiator of these discussions. We were hopeful that if we could sit around a table and discuss these things in a gentlemanly way that they could be resolved. However, as history has shown, we were disappointed in our anticipation of this. Unfortunately, I feel that ophthalmology has taken the attitude that they are going to go their own separate route. This is a sad commentary as far as the public is concerned. I really don't feel that they can benefit from this schism between the two groups. I personally am not optimistic about the situation improving in the foreseeable future.

**CJO:** I have noticed that sometime ago ophthalmology used to stress the inability of the optometrist to recognize eye diseases, particularly glaucoma. We had a rash in the early 1970's and late 1960's of glaucoma

days. The glaucoma days disappeared for a number of years and now they have started to come back. You will see that they are now talking about the ability, the super ability of the ophthalmologist to be able to recognize systemic diseases in the eye, inferring all the while that we are unable to do so. It strikes me now that you just have to open the newspaper to see reports of medical groups and physicians particularly ophthalmologists speaking to lay groups with this matter consistently being stressed. Have you noticed that?

**Dr. Huber:** Yes. I would like to just comment on the fact that unfortunately I feel a lot of these trends are politically motivated. Scare tactics that have been used have included glaucoma, cataracts, and the fact that we could not dilate the pupil and see the total fundus, the use of pharmaceuticals.

And it seems to me that even when these things are resolved by optometry there is yet another hurdle to go over. A typical situation existed at the Waterloo School when the pharmacology became suspect. The school had an independent study done and the report came out in a very positive way that the students were properly trained in the use of facilitative pharmaceuticals. The pharmacology training had hardly been resolved when ophthalmology once again questioned our ability to recognize pathology. I understand that as a result the school has asked McMaster University to study and report on the quality of this training.\* Unfortunately I must conclude that such attacks are politically motivated, not by any desire to improve service to the public.

**Dr. Brown:** The situation that arose in 1978 with the Drug Directorate when the COS tried to have Health and Welfare put a number of ophthalmic drugs, practically everything next to water under schedule F\*\* is another example of this trend.

As a result of our presentation to the Drug Directorate and our dialogue with them not only were

none of the ophthalmic drugs put on Schedule F, we have gained a far greater stature today amongst pharmacologists and certainly with the Department of Health in Ottawa than we have ever had before. It appears to me that every time something is thrown at us we are capable of dealing with it.

**CJO:** It is thought that the scope and practice of a profession can be influenced by two main factors: the educational institution and the profession. Which of these two groups has been the most influential in developing optometry and is there not a justification that the two should cooperate in order to evolve a more comprehensive unifying plan for the future?

**Dr. Huber:** In response to the latter part of your question there is no question about the idealism of a co-operative approach to the determination of the scope and mode and role of the practice of optometry. However, up to this point in time or in very recent times, the educational institution has been far more influential in the determination of this particular issue. I don't say that as a criticism or in any derogatory way. We are speaking of the University of Waterloo which is the resource for 9 out of 10 provinces in Canada and it is a very strong and progressive institution. Unfortunately the profession has not been as strong in its consideration of this particular issue so that by our own default the educational institution, or academia has determined our course. It was interesting to sit in on a meeting a year ago in B.C. during a debate on the use of pharmaceuticals. The debaters were Dr. Bert Jervis and a young recent graduate from Waterloo. Of course they were of opposed views, especially in the area of treatment drugs. This was perhaps an example of the error in thinking that the professions could easily influence practitioners after they graduate. I think they are receiving the training at the undergraduate level to anticipate what they are going to be practising. The greater example of this today is in the United States where young

\*Ed. Note.

The LaRiche study on optometric practice reports favourably on the quality of training in this area. Reference. LaRiche, H.W., 1980 - Vision Care - A Survey of Optometrists in Ontario, Dept. of Preventive Medicine Biostatistics, Faculty of Medicine, University of Toronto.

\*\*Schedule F lists drugs available only through a medical prescription.



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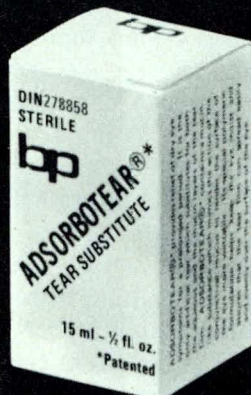
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graduates are coming out fully convinced that they are qualified to use treatment pharmaceuticals. The point is that I don't think this is really the consensus of the profession at large. So, to answer your question, I would say that up to this time the educational institutions here in Canada have had a far greater influence on the determination of scope. However, I think the profession is very much aware that this has come about. Certainly a consideration of this situation is now a definite priority within C.A.O. as a result of this awareness.

**CJO:** Optometry has not always been blessed with strong institutions. Can one of you recount the evolution of optometry in the field of practitioner training?

**Dr. Brown:** Historically public acceptance of optometry has been built upon proper training and service. The quality of training has been confirmed by adequate legislation. Practitioners banded together to foster proper standards by self education. They founded institutions and then approached Government to obtain legislation. So from an historical aspect the profession was the primary factor in setting up institutions and determining what subject matter should be included in the curriculum to produce practitioners with the desired qualifications. Post graduate education although administered by the school was practitioner orientated.

Practitioners made it a personal responsibility to study and read. The Optometric Extension Program and the summer courses in Saskatoon and at the Ontario College in Toronto are prime examples of this. The profession by deferring to academicians and university traditions has lost influence in the development of curriculae. The off-campus projects have rectified some deficiencies by providing clinical experience. Practitioners have on their own developed expertise in many fields such as low vision, learning disabilities and contact lenses, the knowledge of which is now a part of formal curriculae in the schools.

Residency programmes are of value because they provide both better instructors at our schools and practitioners for the field. But one cannot obtain proper legislation unless the profession has the training and the institution to back the demand for legislative changes. We should not forget that our admittance to Waterloo was achieved only after demonstrating the suitability of optometric training as a university discipline. The profession and the school have each enjoyed its heyday in formulating curriculae. Progress in the future will result from cooperative efforts of the profession and the faculty to produce practitioners able to meet the ever changing needs of this society.

**CJO:** There has been a growing demand for optometric certification of specialties. Should the process be institutional or professional in such approval?

**Dr. Huber:** I think that your comment that there has been a growing demand is well taken. The fact that there is a demand is being responded to by the educational institution in residency programs is something which I personally don't have any particular quarrel with. I understand that most of the schools rationalize these residency programs on the basis of actually educating somewhat better teachers as opposed to better practitioners. However, I think that the sooner we get some of these so-called specialists into private practice the better off we will be because I think there is a need, there is an area for them to practice in, particularly in larger urban centres. I think that the profession should have a very definite input in terms of certifying these people but I don't think it is a black and white question of either the profession or the educational institution. Again, I think that a cooperative approach should be taken. There are definitely needs in terms of pediatrics, geriatrics, low vision in a number of regions of Canada for this sort of specialization within the profession.

**Dr. Brown:** I would like to agree with Dr. Huber but I would hope though that optometry would not make the same mistake that has been made by medicine in Canada where we have got well over 50 per cent of physicians who are specialists. As a result of this, medicine is having a great deal of difficulty in rendering a real medical service to all Canadians. While the development of the super GP is an admirable goal, and certainly one that optometry should aspire to, there is always that question of maintaining a balance. Take the case of the small town optometrist. It is not uncommon to examine a three months old baby and then a patient that is a 93 year old lady. He or she (the optometrist) must romp all over the field from contact lenses to people of all ages with all sorts of difficulties from low vision to goodness knows what. All of which is very challenging and very interesting. Optometry must remain aware of the fact that while there is an area for specialties there is also the established need for the general practitioner to meet everyday demands for primary vision and eye care.

**CJO:** The 1970's have been the age of consumerism. What has been its effect on optometry in the 70's and its outlook in the 80's?

**Dr. Brown:** It is going to have a profound impact upon Canadian optometry. Certainly with Part I of the 1976 Competition Policy Act passed in Ottawa and Part II just sitting in the wings there is potential for a great deal of change. The idea of the portability of the prescription and the idea that each and every patient will receive a prescription automatically is certainly a part of government bureaucratic thinking. They do pay the vision care bill now in seven of the ten provinces. And possibly they will be paying in all of them before too long. It is bound to have an effect upon where the prescription goes and where it is filled. You could take a look at it from a point of economics, or you could also take a look at it from our traditional view that the filling of prescriptions is the therapeutic end of optometry. The



optometrist continues to feel that in order for the diagnostic service to be properly carried out they should provide the therapeutic service too. So the future of consumerism in optometry is just beginning to touch the tip of the iceberg.

**Dr. Huber:** Optometry is probably unique in the sense that they do participate with the consumer in terms of both services and materials. What I find somewhat disconcerting is that the government has not distinguished between the ophthalmic appliance as a medical device or a consumer item. I think that in terms of materials, if one buys a microwave oven or if one buys a car, or if one buys "glasses" that is one aspect. However, I think when you get into health services you cannot be too certain that the consumerism trend is all that beneficial. Health care is a pretty specialized area and I think the diagnostic procedures of the diagnostic phase of our practice as Roy mentioned probably lends itself less to consumer scrutiny. I really don't think health services have a lot to be gained by getting onto the consumer bandwagon.

**Dr. Brown:** But of course then, the government will say to you there that the diagnostic end is the health care portion, the other is a purchase item. And here again, the consumer is very aware of how he or she is going to appear on the street. When you take a look at what really goes on in the consumer's mind when it comes to vision and eye care you'll find that first of all there is concern about blindness, they don't want to go blind. They want to see. The second thing that enters the consumer mind is style, what kind of style is he or she going to have and down the road comes the cost of the style. So I think optometry in order to render a complete service, the one stop service to put it in a consumerism form, is going to have to take a long look at its treatment service end. It is going to have to expand itself. Many people are still pulling open a drawer with a few frames in it and that no longer satisfies the consumer today. They expect a better choice in the

automobile they drive and in the clothes they wear . . . and their glasses. While they may be a health aid, they are still worn on someone's face. As I have travelled across the country from one side to the other the one complaint I have repeatedly encountered is that optometry has not kept itself up-to-date in providing adequate frame selection facilities. If Optometry is going to stay alive in this area, the profession is going to have to take a long and realistic look at itself.

**CJO:** Do you foresee that government on the basis of qualifications would eventually restrict optometry from participating in the treatment service? I am thinking of the division of services which was proposed some years ago in optometry, that ophthalmology would do only medical care, optometry would take care of the physiological aspects and the optician would do all the mechanical work.

**Mr. Schaefer:** That role model is a contradiction of the free enterprise system. The consumer, not government will decide who will provide the services to them based on quality and performance. That type of consumer issue we have always been able to deal with. The fact is that optometry in the 1970's and the 1980's is starting to respond positively to this aspect of consumer needs. We have recently talked about the advertising of optometric fees and services and come to an agreement that there are artificial barriers within the optometry Acts of every province of Canada that keep needed information away from the consumer. It works to our benefit as well as to our detriment. I honestly feel that the consumer should know before he or she goes into a professional office what services you are prepared to provide and at what cost. That isn't something that optometry should be threatened by. In terms of the other consumer issues such as standards of practice and licensing procedures we have already introduced the idea of public representatives on licensing and disciplining committees of each association.

That is something optometry is voluntarily moving towards. Again, that is part of the new consumer movement. You have to recognize that it is not just the advertising. It is also standards of practice, licensing, and a question of the monopolistic position that the profession holds as a whole. Well, do we in fact have such a close-door policy a position of monopoly that we are artificially trying to protect? My answer to that is no. In optometry we really believe in the theory that when you serve the public, you serve the profession. We will grow because of service and so we shouldn't be afraid of these things. All we have to do is understand them and move towards them in a positive way. There was a very good survey in the U.S. that pointed out why and how a consumer picks his eye care practitioner. Quality of care was not first and foremost in the consumers mind. It was accessibility, both in terms of location, hours of operation and the efficiency of service in terms of time. All of these are aspects of consumer needs as a purchaser. By addressing them you do not compromise the standards of practice or the ethics of an optometrist as a provider of health care. But what you are doing is responding to a consumer need. As long as we are providing quality care with the access to the public based on their concept of service optometry will prosper and remain at the corner stone of vision care in Canada. It is as simple as that.

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