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Brian O'Riordan, Executive Co-ordinator
Health Professions Regulatory Advisory Council
55 St. Clair Avenue West
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Dear Mr. O'Riordan

On behalf of the College of Optometrists of Ontario, I'd like to thank HPRAC for the opportunity to provide input on certain issues in the eye care sector. As you know, the College has the legislated mandate to govern the profession of optometry in the public interest. It is through this "public interest lens" that the College approached the questions HPRAC has put out for stakeholder input.

I'm pleased to provide to you our response to HPRAC's questions. We are hopeful that this submission will assist HPRAC in developing robust recommendations for the Minister's consideration. Furthermore, we look forward to working with HPRAC over the next several months as it develops those recommendations.

Best regards,

Murray J. Turnour, O.D., M.Sc.
Registrar

1 & 2. The College believes that issues in the eye care sector (as elsewhere in the healthcare system) should be viewed with consideration to maximizing patient safety, quality of care and opportunities for collaborative practice. Patient safety will be enhanced through strong regulation that Colleges enforce fairly and consistently. Quality care will be reasonably assured when patients receive care from regulated professionals practising within their scope of practice. Collaboration at the patient care level will be enhanced when the regulatory structure is amended to allow for a broader range of business relationships that preserve patient safety and enhance the quality of care.

In order of priority, the College would suggest the following issues need to be considered during this review.

Issues	Resolution
1. Breaking down the existing barriers between professions in a silo-based eye care system.	The Government must take on its leadership role to ensure that issues like interprofessional collaboration and increased scope of practice actually occur, not simply that they are able to occur.
2. Aging patient population and the increasing need for eye care services combined with insufficient ophthalmological resources.	Enhance collaboration between and among members of the three professions with each allowed to work to maximum scope of practice and training, i.e., optometrists prescribing drugs and following patients post-operatively.
3. Globalization and vertical integration of the eye care industry, i.e., turn-key, retail operations that provide all services.	The system has to recognize the trend toward globalization and vertical integration and be prepared to ensure that access to quality eye care is not compromised by corporate interests.
4. Cross-jurisdictional mobility of practitioners.	Embrace the concept and welcome the advances that mobility can foster.
5. Technological advances in diagnosis and treatment.	Motivate practitioners to capitalize on technological advances and to use costly equipment more efficiently through joint ownership, sharing and collaboration.
6. Internet dispensing of glasses and contact lenses.	The Ministry must take the lead in protecting the public from trends that jeopardize patient safety and violate Ontario legislation or standards of practice.

The current eye care delivery model can be characterized as a silo-based system wherein professional associations do everything that they can to protect their members' "turf". Overlaid on this are corporate profit interests that may impact on patient access and quality of care. This current review gives HPRAC an excellent opportunity to develop a plan to move toward a collaborative practice model geared towards the provision of quality health care that addresses the needs of the public. In developing this plan, HPRAC will need to achieve momentum while not moving the system too far too quickly.

3. Regulation around business practices and business relationships between and among members of different regulated professions and other persons must ensure that:

- patient access to quality health care is not impeded;
- there is no interference with the exercise of professional judgement;
- standards of practice are not circumvented;
- there is no impediment to the application of regulations that would otherwise apply to a regulated health professional; and
- interprofessional collaboration is facilitated.

Among the "players" in the current review, only the health regulatory colleges have the legislated mandate to protect the public interest. Other players have different interests including scope of practice issues and profit motives. The role of the Colleges is to identify the risks to patient safety and quality of care that may result through different types of business practices or relationships between and among regulated professionals and other persons. The College believes that the public of Ontario has a right to expect the same high standards with respect to business practices that they expect with respect to clinical care.

The College reviewed a number of different models for business relationships and determined that some restrictions are necessary to protect the public interest. A more detailed description of these restrictions is given in the answer to Question #7, below.

4. The principles that guide the development of regulations for regulated professionals around business practices and relationships should ensure that the public interest is protected by (i) minimizing the risk of harm to the patient, (ii) maximizing the quality of care provided, and (iii) enabling collaboration between and among professionals.

The Courts have held "that a fiduciary relationship exists where one party agrees to act on behalf of, or in the best interests of another person and, as such, is in a position to affect the interests of that other person in a legal or practical sense. As such, fiduciary relationships are marked by vulnerability in that the fiduciary can abuse the power or discretion given to him or her to the detriment of the beneficiary...Thus, while a fiduciary obligation carries with it a duty of skill and competence, the special elements of trust, loyalty, and confidentiality that obtain in a fiduciary relationship give rise to a corresponding duty of loyalty." (LaForest J. in Hodgkinson v. Simms, [1994]3S.C.R. 377)

The relationship that optometrists have with their patients meets the test to be considered fiduciary, carrying with it the corresponding obligations. Accordingly, regulations must be developed to support and nourish this fiduciary relationship – not to chip away at it.

The primary purposes of regulations and standards of practice are (i) protection of the public, and (ii) assuring quality care. While achieving these purposes, regulations must also be fair to regulated health professionals. That is to say, they cannot be so onerous as to make it impossible for regulated health professionals to make a living or to work together. If that were the case, no one would enter professional life and the public would suffer.

The regulatory environment should ensure that health care decisions are made in the best interest of the patient and not for business or profit considerations. In this regard, "referral for profit" is seen as a conflict of interest. Accordingly, many jurisdictions have regulations for different professions that prohibit giving or receiving, or offering to give or to receive, payment for referring patients. Another safeguard is to have professional misconduct provisions prohibiting one regulated health professional from permitting, counselling or assisting another regulated health professional to perform an act which would be professional misconduct. To further protect the public, this provision has been included in the College of Optometrists' proposed amendments to the Professional Misconduct Regulation. This provision, however, can only be applied to regulated health professionals if it is included in the professional misconduct regulations, and cannot be applied to other persons who are not regulated.

The Council of the College believes that public trust in the profession and the professional will be maintained when members are held to high standards. Where business relationships are allowed, professionals need to maintain control over the following aspects of their practice:

- the services that are provided;
- who is accepted as a patient;
- the release to the patient of a copy of his or her prescription, order, requisition or similar document that reflects the true recommendations of the health care professional;
- the fees that are charged; and
- the maintenance, care, custody and control of patient records.

5. For more than 15 years, the College has been attempting to amend the Conflict of Interest provisions in the Regulations. In the College's opinion, this delay in bringing a new Conflict of Interest Regulation into force has not been in the public interest. Society has changed considerably over that period, as have the professions. Unfortunately, the Regulation has not changed. Not only is the current Regulation outdated, there is some concern that parts of it would not withstand a legal challenge. We believe that this delay has exacerbated problems between the professions of optometry and opticianry. The government must allow the College to bring forward a new Regulation.

The College's proposed Conflict of Interest Regulation is designed to allow for collaboration between professionals at the patient care level while preserving the independence and accountability of the optometrist's professional judgement. The College of Optometrists recognizes that what constitutes a conflict of interest is situational. That is to say, a given behaviour may be a conflict for one person or in a given circumstance, but the same behaviour would not be a conflict for another person or if the circumstances change. The development of the Conflict of Interest Regulation took into account the current and historical differences and similarities between the professions of medicine, optometry and opticianry. Factors considered included the relationship with the patient, the environment in which the profession is practised, mode of practice, scope of practice, training and degree of integration within the health care system. Overall, it was determined that there are more similarities between optometry and medicine than between optometry and opticianry.

i. Optometry and opticianry are practised in different environments, with different relationships and different goals. For optometrists, clients are patients. For opticians, clients are customers. Optometric services are provided according to the medical model of providing diagnostic and treatment services. Opticians provide ophthalmic appliances primarily in a retail setting where the cost of an appliance is the foundation upon which the business model is based. These differences bring about different relationships and create different opportunities for conflicts to arise. How optometry and opticianry deal with business practices and relationships will necessarily be different. Accordingly, the College does not believe that a common set of conflict of interest regulations for optometry and opticianry is appropriate.

ii. Dispensing eye glasses, contact lenses and low vision aides is authorized to the professions of medicine, optometry and opticianry. Accordingly, it would be reasonable, insofar as advertising of product is concerned, that the regulations should be common among the three professions.

iii. As noted in (i) above, there are significant differences in the relationship that optometrists have with their patients and the relationship that opticians have with their customers. For this reason, a common code of ethics would not be appropriate. However, the College believes that there is merit in developing a Patients' Charter of Health Care Rights and Responsibilities that would be common across all health care environments.

6. The College of Optometrists believes that, given the significant differences that exist between the professions of optometry and opticianry, a common code of ethics is not appropriate at this point in time. In fact, a recent attempt to identify an existing Code of Ethics for opticians in Ontario was unsuccessful. To assist opticianry, the College would be prepared to share examples of Codes of Ethics adopted by optometric and non-optometric organizations so that they can adapt and apply it appropriately to the environment in which they practise. If requested, the College would be pleased to offer further assistance by commenting on any drafts that were developed.

Should it be determined that consistency across regulated health professions was in the public interest, a more appropriate strategy would be to develop, in consultation with the Colleges, professional associations and patient representatives, a Patients' Charter of Health Care Rights and Responsibilities.

7. The College believes that collaboration between and among professionals can benefit the patient in a number of different ways. That being said, different types of business arrangements have certain benefits and risks associated with them. It should be noted that collaboration and "seamless care and service" at the patient care level can occur under a number of business models; however, some business models promote collaboration while at the same time protecting the public interest, while others provide less protection to the public.

To be practical, business arrangements must be convenient for the patient and for the practitioner(s) involved. Acceptable business models must serve the public interest and not impede access to care nor reduce the quality of care that is provided. Optometry has, for a long time, provided diagnostic and treatment services. The recent expansion of the profession's scope of practice to include prescribing drugs gives patients greater access to the full range of primary eye care services.

The College conducted an analysis, from the public protection perspective, of the benefits and risks associated with various business arrangements between optometrists and other

groups. This analysis looked at the effect that these business relationships may have on the public, the College and the profession. A summary is given below with what are considered benefits in *italics*, and what are considered detrimental to the public interest in **bold**:

Option	Public	College	Profession
Anyone & Anything Model allowing optometrists to enter into business relationships including employer/ employee with regulated and unregulated persons and corporations.	• *Convenient for the public.* • **Employers may limit services provided or who is seen as a patient based on profit considerations.** • **Employers may not be regulated/accountable.** • **Confusion as to who is accountable when there is a problem – the owner or the optometrist?**	• **Confusion over applicable standards in multi-disciplinary settings.** • **Would need authority to deal with members and non-members for investigation purposes.** • **Would need ways to deal with big corporate chains.** • **Cost of regulating will increase exponentially.**	• *Facilitates interprofessional collaboration.* • *No limitations on types of multidisciplinary practices.* • **Loss of independence when profit is the motive and when the optometrist is subjugated to the goals of unregulated employers.** • **Professional judgement and access may be controlled by employer.**
Limited Employment Relationships between optometrists and other regulated persons or professional corporations.	• *Employers are all regulated professionals who are accountable to their own College.* • *Convenience of collaborative care.*	• **Will need to deal with members and non-members (but who are regulated by another College).** • **Will need to cooperate with other Colleges on development of standards and for investigations.** • **Open to a Charter challenge from excluded entities like retail corporations selling glasses.**	• *Facilitates interprofessional collaboration.* • **Loss of independence.** • **Confusion if standards are not synchronized between Colleges.**
Independent Contractor Model	• *Decisions within scope are made by regulated professionals based on medical considerations, not profit considerations from the sale of appliances.* • *Convenient and seamless care when professionals come under one roof.* • *Patient knows who is accountable for which service(s).*	• *College deals with members.* • *Standards are easily enforced.*	• *Facilitates interprofessional collaboration.* • *Maintains independence.* • *Professional judgement is not subjugated to employer.*

Option	Public	College	Profession
Outright Ban on business relationships between optometrists and other persons whether regulated or not. (essentially the status quo)	• *Decisions are made by regulated professionals in the patient's interest.* • *Patient knows who is accountable for the service(s) provided.* • **Limited delivery models and possible access issues.** • **Lack of convenience.**	• *Will deal with members.* • **Open to a Charter challenge.** • **Members may object to outdated regulation and therefore enforcement is difficult.**	• *Maintains independence.* • *Professional judgement is not subjugated to employer.* • **Not practical or desirable in today's environment. Isolates professional and limits collaboration.**

After considering the options available, the College concluded that the most appropriate option from a public protection perspective is to amend the Conflict of Interest Regulation to allow optometrists to enter into business relationships with any person or entity as an independent contractor. This model has the advantages that it allows for health care services to be provided in a collaborative environment that is convenient for the patient and that provides seamless care with clear accountability and transparency. Additionally, independence of professional judgement is maintained.

8. Patient confidentiality must be balanced with the information needs of the professionals providing services. When collaboration takes place, patients expect that relevant information will be passed on to the next professional to allow for optimal care. However, patients also expect that their personal health information will be kept confidential, so no more information than is necessary should be transferred without the express consent of the patient. In a collaborative practice setting, clear protocols will be necessary to ensure that patients understand who will have access to what information. Some variation will be possible depending on the nature of the setting, the services being provided and the professionals involved.

9. There are several important differences between the relationship that pharmacy has with medicine compared to what has been proposed by some for the relationship between opticianry and optometry. Looking at whether or not the environment should be regulated and, if so, how it should be regulated, gives only part of the picture. It is our understanding that the majority of physicians practising within pharmacies are not employees of the pharmacy, but rather, are working as independent contractors. The majority of a physician's practice will be the provision of services that are insured by OHIP and payment will go directly to the physician not to the pharmacy.

In the College's opinion, regulating the premises where a profession is practised is necessary, but does not go far enough. While extending the authority of the College to include the physical environment would provide to the College an additional tool to help ensure quality care, significant additional powers, such as those found in the *Drug and Pharmacies Regulation Act* would also be needed in the eye care sector to assure the public is not put at risk. For instance, the *DPRA* provides for additional safeguards over and above regulation of the premises. Specifically, ownership and control of pharmacies is restricted by S. 142 (majority of directors must be pharmacists, and majority of shares must be owned by pharmacists). Additionally, S.140(3.1) gives the Discipline Committee of the College of Pharmacists authority over "a person who has been issued a certificate of accreditation or the directors of a corporation". These safeguards are in place to protect the public interest. The College believes that an effective regulatory model would give Colleges, at a minimum, control over premises as well as all directors or owners of a facility in which optometric services are provided.

10. We believe that the proposed Eye Network made up of every player in the eye care sector is essentially what we have had for many years and the reason why nothing in the eye care sector has moved forward. Many years ago, the Ministry called together a number of leaders from the broad eye care sector for a Primary Eye Care Review. From the College's perspective, the results of that Review were disappointing. The necessity for HPRAC to consider "issues in the eye care sector" is a further example of how unsuccessful the process to find solutions and capitalize on opportunities has been. We feel that the reason things have not moved forward is precisely because of the diversity of stakeholders – each with differing interests, goals and mandates – making identification of a shared goal impossible.

Eye care policy cannot be the subject of a negotiation process where the public interest is offered up as only one factor to be considered in the hopes it will gain consensus around a vast table of varied and sometimes opposing interests. What needs to happen, in our opinion, is to establish principles around interprofessional collaboration and delivery of quality health care that meet the needs of the public. The Colleges, with their shared legislative mandate of protecting the public interest, should be charged with the responsibility of identifying the opportunities to enhance the public interest and remove the barriers to collaborative care. Unless this is done, and done quickly, the status quo can be expected to continue.

As the College stated at its meeting with HPRAC, the Minister needs to call the leaders of the three colleges to a meeting to lay out her expectations and timelines, and then hold the colleges accountable for determining the best course(s) of action. Challenging the

three Colleges to establish a shared vision is the first step. Once the three Colleges have established the principles of collaboration based on patient needs, public interest and sound health care policy, other interested stakeholders would be invited to the table to contribute input on specific issues.

11. Up until very recently, health care in Ontario has been delivered through a silo-based system characterized by stand-alone practices in which only members of the same profession practised. At the regulatory level, Colleges were also isolated and independent of each other. The Government was content to deal with each profession and each regulatory body separately. For a number of good reasons, Government is setting new expectations for regulators and professionals around collaboration. In order to bring these new expectations to reality, attitudes need to change.

i. Respect can be fostered through understanding the roles and competencies of the other professions. This could be accomplished through a system of mentoring at every level – student, practitioner and regulator.

ii. Mentoring is currently occurring on a sporadic level, but the trend is increasing. Students at the University of Waterloo, School of Optometry have exposure to medical students and physicians in a clinical setting. They also receive training from opticians in their clinical rotations within the School. As noted in the next question, some optometrists work side by side with ophthalmologists. More such opportunities need to be created or encouraged. At the regulatory level, there is very good cooperation on many shared projects both within and outside the Federation.

iii. Joint education at every level is one of the best ways to foster respect and enhance collaborative care. Optometrists regularly attend educational programs directed towards ophthalmologists, and some ophthalmologists present lectures at optometric events. Occasionally, optometrists are invited to speak at ophthalmological gatherings.

iv. In the present health care delivery environment, a joint quality assurance program would likely be extremely difficult to develop and manage.

12. Interprofessional collaboration currently exists at the individual health care provider level for the benefit of patients. Where a refractive correction is necessary, patients have

the choice of having the optometrist fill that prescription or of going to an optician to have it filled. In some situations, there is a close proximity between the optician and the optometrist, while in other situations there is considerable distance. The College has been attempting for 15 years to have the current regulatory barriers amended to allow for a closer working relationship between optometrists, opticians, and other persons. The expectation that a model that will protect the public and make all stakeholders happy at the same time has proven to be elusive. What is certain is that movement is required. The College sees the proposed Conflict of Interest Regulation and the independent contractor model as a significant step forward that respects public protection and facilitates interprofessional collaboration.

Optometrists and ophthalmologists already work collaboratively under various models to meet the needs of patients. If an optometrist diagnoses a condition requiring the expertise of an ophthalmologist, a referral is made. The referral may be to a community or hospital-based ophthalmologist, depending on the situation. Systemic problems that HPRAC has addressed in the past have served to hinder such arrangements in some circumstances. For instance, the fact that ophthalmologists receive a higher consultation fee from OHIP if the patient has been referred by a physician has sometimes led to the situation of the patient being referred indirectly through the general practitioner leading to unnecessary delays and increased costs. The recent addition of the Optometrist-Requested Assessment to the OHIP Fee Schedule recognizes the value and importance of optometric referrals to the health care system.

In other situations, optometrists and ophthalmologists may work in the same office. For instance, it is quite common to have both professions working collaboratively in laser refractive surgery centres. There are also examples of optometrists providing primary eye care services within ophthalmologists' practice. In some rural or remote communities, ophthalmologists may see patients locally in optometric practices, improving access and convenience. These various collaborative care models have developed using a variety of business models to support them.

Regular, open and frank communication between the three colleges will lead to the identification of further opportunities for collaboration at the regulatory and clinical care levels. A formalized body consisting of the three Colleges with expectations placed on that group by the Ministry will be essential to ensure that the conversation yields results that move the collaborative practice agenda forward.

13. The College agrees that evolution of professional roles is both inevitable and desirable in the public interest. Health professionals should not only be allowed to

practise to the highest level of competence, they should be encouraged to do so. However, professions can't be allowed to unilaterally expand their scope of practice. A number of factors need to be considered in determining how and when it is appropriate to change a profession's scope of practice. Some of the factors relevant to expansion of a professions scope of practice have been canvassed in HPRAC's work on **Criteria for Regulation under the RHPA** and **Criteria for Including a New Controlled Act in the RHPA**.

i. Prior to authorizing any scope of practice changes, the Ministry needs to develop, in consultation with the professions, an effective and acceptable mechanism to encourage members of each of the three professions to practise at the highest level of their training within their respective scope of practice. The College believes that there needs to be accurate health human resource information. The Health Professions Database that the Ministry is establishing will go a long way to providing supply information. This human resource information will need to be balanced against the "demand" side of the equation, that is, the projected incidence and prevalence of conditions of the eye and vision system requiring services falling within the scope of practice of each of the three professions. An undersupply of professionals relative to demand for health services is a critical indicator that a scope of practice change for another profession may be appropriate. To protect the public interest, members of that other profession must have the necessary training and education to provide competently the services within the expanded scope of practice before any such expansion is authorized.

ii. The College of Optometrists is confident that the members of the three professions are competent within their scope of practice. However, recent legislation to facilitate increased inter-provincial mobility has raised concerns that less qualified professionals may be allowed to be registered in Ontario. The College has raised concerns with its Quebec counterpart over the lack of competency-based entry-to-practice examinations in that jurisdiction. In opticianry, there are concerns about the significant variation in the length of the training programs. These issues may warrant further study.

iii. One of the goals of the RHPA is to allow for the evolution of scopes of practice of the professions. The Government has, with recent amendments to some profession-specific Acts, allowed for that evolution to take place. The "strain" on the system that has resulted in this evolution has come from a number of different sources including health human resource limitations, demographic shifts, and changing patient expectations.

In the present circumstances of limited human resources and increasing demand, evolution of the scope of practice of one profession may impact on the nature of the services provided by another profession, but it is unlikely to significantly impact financial sustainability of another profession. In fact, it may have positive impact by allowing the members of the other profession(s) to provide services requiring a higher level of knowledge, skill and judgement, which presumably would be reimbursed at a higher rate.

Patients need to understand that they are a partner in the decision-making process. In being a partner, they have a responsibility to be informed about their options for treatment. Practitioners of all stripes must know and accept that fact, and communicate that message clearly to patients to ensure that the professional's personal interests take a back seat to the patient's interest.

14. As stated previously, the College's preferred future is focused on minimizing the risk of harm to patients, increasing quality of care and enhancing collaborative care through responsible changes to the legislation and standards of practice. Progress in these areas will occur when the following take place:

- Implementation of the amended Conflict of Interest Regulation for optometry to advance the public interest by allowing for increased collaborative care while minimizing risk to the patient.
- The three eye care professions working collaboratively, each within its own scope of practice, to provide high quality care to the public. This would also enhance accessibility to secondary and tertiary eye care services.
- The integration of optometry into the family health team system.
- The three Colleges being given a clear mandate and a forum to discuss and resolve patient care issues in the public interest without the encumbrance of outside stakeholder involvement. This would entail putting an end to the "one voice, one vote" for each and every stakeholder that expresses an interest in an issue.
- Development and implementation of a Patients' Charter of Rights and Responsibilities for the broader health care system.