# Podiatrists and optometrists mounting provincial lobby campaigns to get greater treatment authority

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"If you take your car to a garage because it's making a funny noise, and the mechanic there only knows about front wheels, he is not going to be much help in diagnosing engine trouble. He may even exacerbate the problem by insisting that it is the front wheel that is at fault and fiddling with that. You'll drive off with your engine getting worse and a hole in your bank balance."

This analogy is how Dr. John Bennett, CMA director of professional affairs, explains the concern among doctors about the demands of some non-medical professional health groups to be allowed to practise primary health care. The two groups around whom this concern has crystallized are optometrists and podiatrists. Their professional associations have successfully lobbied in various provinces for an upgrading of status and permission to use scheduled drugs, and reactions among local doctors have varied from resigned acceptance of a further undermining of their own status to active protest against what they perceive as a threat to patients' welfare.

No medical practitioners question the ability of optometrists to deal with refractions and fit and sell glasses, or of podiatrists to treat injuries and simple disorders of the feet. They do a useful and important job. As Dr. Norman Rigby, executive secretary of the BCMA says, "Non-medical health professionals are very useful adjuncts to the health care team; they can contribute a lot." Dr. Bennett agrees: "There's certainly a place for all these people — optometrists, chiropractors, podiatrists, just as there is for physiotherapists and laboratory technicians." But both doctors add the rider, "It is the medical practitioner who must be the leader of the health team — he is the only one who has the training to diagnose for the whole body."

### Concern for training

It is the question of training that concerns the doctors. Their main argument, in Dr. Bennett's words, is that "you must generalize before you specialize. The bulk of medicine is diagnosis; you can find the appropriate treatment in the textbook. The majority of training in medical school is aimed not at becoming a technician but at developing the skill of a diagnostician. Nobody but a conventionally trained MD has this skill for the whole body."

His views are echoed by Dr. Douglas Waugh, executive director of the Association of Canadian Medical Colleges, which keeps an eye on medical education in this country. "What is unique in medical education is the way students are trained to examine any pathologic condition and evaluate possible therapy in the context of the whole body. Other groups are either just looking at disease of a particular organ, as in the case of optometrists, or at *all* diseases from one point-of-view as chiropractors do." By all means let non-medical professional health groups employ their skills when the patient's problem has been identified as being on their pitch, but the primary process of identification should be left to the people trained to do it: physicians. "If an individual goes to an optometrist and he diagnoses cataracts, he won't be able to do all the tests — blood sugar, urine and so on — for diabetes," points out Dr. Bennett. "Unless the optometrist sees fit to refer him on to a general practitioner, the results for the patient could be disastrous."

The rumbles of doctors' distress about non-physician encroachment on their traditional role as the primary care providers have become louder on the particular issue of drugs. Provincial groups of optometrists and podiatrists have independently been pressing for the right to use certain drugs in their practices as diagnostic aids, anesthetics and, in some areas, therapy.

While only orthodox physicians (along with vets and dentists) had access to scheduled drugs, they at least knew that individually and professionally they were the only professionals with access to products that require careful monitoring and skill in prescribing. "No drug is always safe in all circumstances. One needs to know all the possible dangers; one must be aware of a preparation's potential systemic as well as local effect. This is why medical students not only spend at least 120 hours of their training on pharmacology, but also study in great depth the pathophysiology of disease so that they can cope with the complications of drug therapy," comments Dr. Waugh. It is not simply a knee-jerk reaction of territorial jealousy when doctors fight to preserve their exclusive use of drugs, argue medical educators, administrators and professionals; it is simply that they are the only people qualified to do the job.

"If people want to practise medi-

cine," says Dr. Bennett, "let them go to medical school."

According to the non-medical health professionals themselves, this is a "let them eat cake" argument. They argue that they can provide bread-and-butter services, for which they are qualified, thus reducing doctors' work loads. They claim that not only does their training contain more than sufficient grounding in pharmacology, but, because it is focused on a particular area, they have more specialized knowledge than many a general practitioner.

"It is an injustice to my profession," claims Paul Ladelpha, an Ottawa podiatrist, "to clump us together with chiropractors and physiotherapists. We are medical specialists: physicians and surgeons of the lower extremities. The only difference between a podiatrist and a specialist such as a gynecologist is that the gynecologist had to get his MD first and then specialize." Ladelpha asserts that the five US school of podiatry at which most Canadian podiatrists have trained include as much pharmacology as a regular medical school, and he says that graduates of these podiatry courses have trained for as long as most newly qualified doctors. Responding to the point that equal length of study does not necessarily mean equal quality, he is keen to describe podiatry's attempts to establish a school of podiatry in Canada, which unlike the US institutions would be properly accredited, and could share resources with a medical school.

"The problem is just one of funds. The deans of the medical schools only have X number of seats and they're not willing to release any of them to anyone not wanting to go through the general medical course. So we want to establish a separate school somewhere, which would pool resources with a neighbouring medical school. But no provincial government at present will put up the facilities for a school of podiatry. We want to ensure that there is an adequate supply of properly qualified podiatrists in Canada so that Canadians have proper feet care. But politicians are swayed by other concerns."

In spite of Ladelpha's confidence others have doubts. One province where podiatrists have successfully extended the scope of their practices is Alberta, where since Mar. 1 this year they have been allowed to use and prescribe antibiotics and steroids systemically. They are also allowed to use propoxyphene, an analgesic probably selected because it was "safe". Commenting on the Order-in-Council that authorized the use of these drugs by podiatrists, Dr. Robert Clark, executive director of the AMA, says, "The AMA believes that this decision was not in the best interests of the health of Albertans. We are not convinced that podiatrists know when to use a systemic drug, which one to use and how to use it. We are not convinced that they can recognize drug interactions or the complications of drug therapy; nor do we feel that they can adequately deal with these interactions or complications . . . propoxyphene, for instance, is at least habit-forming if not addicting."

Dr. Clark points out that the Albertan legislation that gives podiatrists the authority to practise allows them to treat simple foot disorders, but the AMA advised the government 10 years ago that podiatrists are overtrained for the work they do: "we concluded that foot-care technicians with 2 years training, working under the supervision of physicians, could fill the role quite adequately." His association is not satisfied with the adequacy of podiatric training in pharmacology and therapeutics, nor with the opportunities they have for refresher courses to enable them to maintain their competence. But despite these reservations and doubts expressed over the last 10 years, Alberta doctors now find podiatrists usurping many of their traditional functions.

**Déjà-vu**

When one looks at the moves afoot by optometrists, one has an I've-been-here-before feeling. Many of the arguments submitted by optometrists to justify an extension of their activities run parallel to those of the podiatrists.

Optometrists claim that, as specialists, they can offer more comprehensive treatment than many a GP; they suggest that they can lighten the physician's burden by screening and treating those patients whose problems fall into their competence; they argue that their training courses are just as adequate as any medical school's with regard to pharmacology. Moreover, optometrists have a powerful weapon in their armoury that the podiatrists, to their regret, lack. There is a school of optometry at the University of Waterloo, and a smaller one attached to the University of Montreal. Pointing out that Waterloo graduates have a Canadian-recognized doctorate in optometry, optometrists have rolled into battle with the attractive plea that they are the frontguard of preventive and care services, oriented to those vision problems not classed as disease. It's a plea that strikes a responsive chord in health administrators' hearts in these post-"New perspectives" days.

One of the optometry battlegrounds has been New Brunswick, where the provincial legislature is about to pass an act that will permit holders of a Canadian doctorate in optometry to use drugs. The minister of health will announce a list of drugs they can use, after consultation with various parties, in regulations (i.e. the list can subsequently be amended or extended without further legislative action).

The optometrists say that the drugs they want to use are anesthetics or muscle relaxants for diagnostic purposes, and since they are only applied locally in the form of drops these constitute no hazard to the patient. However, a committee of New Brunswick Medical Society has refuted this assertion. In a brief prepared for the legislature, in which the committee made it clear that the society felt the proposed legislation "is not in the best interests of the general public", the hazards and side effects of such drops were discussed. The brief concludes that these externally applied preparations "are not only hazardous to the eye; it is known that they have caused temporary madness, hallucinations, fits and even death . . . the side effects of these medications are uncommon but when [they do] occur the consequences can be horrendous." And the medical brief also argues that the optometry course at Waterloo does not give students sufficient grounding in pharmacology, despite its defenders' claims, nor does it have any input from medical doctors.

Doctors in New Brunswick and elsewhere are especially alarmed by optometrists' suggestions that they

should be empowered to deal not just with simple visual defects but also with a far wider range of complaints — including learning disabilities and drug abuse. M.E. Woodruff, director of the school of optometry at Waterloo, has also suggested that optometrists should advise on immunization against lock-jaw, whooping cough, measles etc. as part of their role in preventive medicine and health education. "As a medical society," wrote the NBMS committee, "we feel that that these objectives are part of the practice of medicine and unrealistic in relation to [optometrists'] present training."

. Nor are doctors anywhere very happy about the fact that optometrists also sell the items — spectacles and lenses — they themselves prescribe; it is clearly a breeding ground for conflict of interest. In Ontario, where optometrists already have many of the rights they are about to obtain in New Brunswick, they are required to sell such items "at cost". But as one Ontario ophthalmologist said grimly, "ask them about the dispensing fees, fitting fees and handling charges they are allowed to bill for — and then decide if the total cost is really 'non-profit'." The medical profession wants to see the optometrists define their role as either that of the professional man or the merchant. Dr. Rigby from BC mocks the idea that an optometrist's services save the patient money: "An optometrist's fees are no lower than an ophthalmologist's, and an ophthalmologist has no vested interest in the results of his treatment."

Dr. Garson Lecker, a Nova Scotia optometrist and past president of the Canadian Association of Optometrists, denies that his association is encroaching on medical territory. "Our role is not that of medicine. We do not wish to usurp the medical role within multidisciplinary health teams. We merely seek to advance the means of providing a service to the patient by suitably qualified practitioners. We have no argument whatsoever with doctors except when they try to restrict how we operate." And, in an afterthought that on pragmatic grounds goes a long way in support of his case, "If we don't do a good job, why do we see as many people as we do?"

Currently, podiatrists are allowed to use drugs and do minor surgery in three provinces (BC, Alberta and Ontario) and optometrists can use drugs in Ontario and within a few weeks in New Brunswick. Elsewhere there is agitation for non-medical health professionals to have access to pharmaceuticals (optometrists are particularly active in Newfoundland, PEI and Saskatchewan and podiatrists are seeking authority to use anesthetics in Quebec). Despite these demarcation disputes though, there are many areas where relations between individual professionals are friendly and cooperative. In New Brunswick podiatrists and physicians live in harmony, and in Alberta no quarrel has arisen between optometrists and ophthalmologists. This has led some observers to suggest that the matter is not just a political issue between professions, but is a push for upward mobility on the non-medical professionals' part in the face of their rivals on their *own* doorsteps — opticians and chiropodists — who are very busy trying to professionalize their status, enhance their powers and formalize their training. Everyone is trying to climb another rung of the ladder, and it's not just doctors, sitting at the top, who are feeling squeezed.

Whatever the motives, there is no doubt that there is some very well-orchestrated lobbying going on in different provinces. And this is something which many doctors are ill-equipped to combat. As Dr. Bennett says, "Compared to most of the non-medical professionals and paramedics, we are a most ineffective lobby. Having been the original primary care providers, we've become entrenched in our assumptions and have not realised the strength of the newly developed allied health care disciplines. So we look as though we are just being on the defensive about our responsibilities and powers. But in the end, if anything goes wrong for one of their patients, it's the medical profession that has to pick up the pieces."

Allied health groups have been able to capitalize on the doctors' disarray by suggesting that their demands are just a family quarrel with the relevant medical specialty. "If the doctors don't want to see their traditional role undermined," says Paul Le Bel, executive director of the Canadian Ophthalmological Society, "they must act in unison. If one specialty is left to defend its own ground, then it looks as though it's just acting out of self-interest. But there are matters of principle involved here."■

# Des mesures de sécurité seront établies pour la recherche sur la recombinaison de l'ADN

Des mesures de sécurité destinées à protéger le public des risques que peut entraîner la recherche sur la recombinaison de l'ADN seront établies par le gouvernement fédéral qui entend ne pas entraver pour autant la recherche en ce domaine.

Les règlements seront établis après consultation avec les provinces et s'appliqueront à toutes les activités de recombinaison des ADN entreprises au Canada, lesquelles seront ainsi réglementées par les mesures de sécurité élaborées par le comité du Conseil de recherches médicales présidé par le Dr. Louis Simonovitch, et énoncées dans les directives de 1977 et dans toute modification ultérieure de ces directives (MITCHELL M, et KAPLAN JG: Medical Research Council committee draws up guidelines for research into recombinant DNA. *JAMC* 116: 802, 1977). La Direction générale de la protection de la santé sera chargée de l'application de ces règlements, sauf dans le cas des bénéficiaires du CRM et du Conseil national de recherches du Canada (CNRC).

Pour la première fois au Canada,