Ontario Podiatric Medical Association

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Hon. Eric Hoskins, Minister of Health
Ministry of Health and Long-Term Care
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Dear Dr. Hoskins,

In the late 1970s, the Davis government started down the road of a serious public policy mistake. It adopted a chiropody model of foot care based on what was then the UK chiropody model. It also invested substantial public resources to establish, from scratch, an educational program, importing chiropodists from the UK as teachers and practitioners and establishing chiropody clinics in public hospitals. Until that time, Ontario had allowed for and in many respects supported the natural evolution of the chiropody model into a podiatry model, consistent with experience across the United States and in other Canadian provinces.

Although a mistake, it appears to have been committed with the best of intentions. As was the case almost everywhere across North America, orthopedic surgeons strongly opposed the evolution of chiropody into a podiatry model that intruded into their professional turf. In Ontario, orthopedic surgeons promised the government that their profession would more than adequately respond to the demand for foot and ankle surgery. The UK chiropody model (as it then was) was also hospital-centric and, thereby, fit with Ontario's healthcare delivery paradigm of the day.

The 30 or so orthopedic surgeons specializing in the foot and ankle in Ontario have been unable to respond to the demand for foot and ankle surgery, particularly for patients 65 years of age and older. Ontario's healthcare delivery paradigm is no longer hospital-centric, the vast majority of hospital-based chiropody clinics have been closed or at least downsized, thereby prompting chiropodists to move to non-institutional practice environments that are unsuited to the competencies they have been taught and the scope of practice they have been granted. The government has also actively encouraged the deinstitutionalization of surgical procedures that can be conducted safely and effectively outside of hospitals. Yet, to the present day Ontario, alone among comparable jurisdictions, has persisted with the 1970s UK chiropody model and, if HPRAC has its way, that model will persist indefinitely.

To protect the fledgling chiropody profession from competition, the Davis government actively discouraged the registration of graduates of podiatry programs in the United States. A statutory prohibition against their registration came into force and effect as of July 31, 1993. To further protect and promote the profession, for the first 12 years of its existence, the regulatory body was housed with the chiropody educational program and for years the head of the chiropody educational program was also the head of the chiropody regulatory body. The prohibition against the registration of new podiatrists was and remains unique to podiatrists wishing to practise in Ontario. In the face of the preponderance of stakeholder comments and unmet

demand for podiatric services, HPRAC recommended the cap stay in place. We, along with the College of Chiropodists, the Ontario Society of Chiropodists, regulators and government agencies in other jurisdictions in the preponderance of stakeholders who submitted comments to HPRAC, strongly believed that the cap must be revoked

For Ontario's podiatrists, the adoption of the chiropody model created serious practice anomalies that have profoundly negative impact for our patients. We are legally authorized to prescribe and administer drugs, but unable to order the laboratory tests necessary to ensure that we are prescribing and administering the right medications. We are legally authorized to perform surgery on the bones of the forefoot, but unable to order ourselves the diagnostic tests that best practices dictate. We are legally authorized to perform osteotomies, but unable to cast or set simple bone fractures and dislocations in the foot. For patients of podiatrists forced by the podiatric cap to practise within the very limited and limiting chiropody scope, the situation is even worse.

At the same time, podiatrists practising in Ontario see patients waiting unacceptably long periods of time for consultations with orthopedic foot and ankle specialists, vascular surgeons and dermatologists to make diagnoses and perform procedures that we are competent to perform and are legally authorized to perform in over 60 jurisdictions across North America, including in Alberta and British Columbia . We also see patients falling through the cracks because no one else in the healthcare system is willing or able to deal with their foot or ankle conditions. Podiatrists practising in Ontario see too many unnecessary patient visits to emergency departments and hospital admissions for problems that podiatrists are competent to handle safely and effectively in their clinics. We see these problems increasing as the seniors demographic (that constitutes about 60% of our patients) grows and will continue to grow for at least the next decade. We see patients subjected to a fragmented and completely inefficient – and completely unnecessary – process of care, including circular referrals that lead to unnecessary and unacceptable delays in diagnosis and treatment, patient frustration and unnecessary system costs.

In this context I'm sure you'll understand why the OPMA could not possibly be more disappointed with HPRAC's report arising from its review of the chiropody and podiatry professions. After waiting eight years for the review to get underway and after an unprecedented 18 months of study, it was dispiriting (to say the least) to read that HPRAC concluded the only change necessary is a renaming of the profession. HPRAC is repeating the same public policy error committed by the Davis government 35 years ago – and for exactly the same reasons. It is incomprehensible to us how HPRAC has supported scope of practice expansions and the regulation of new professions for many other professions as they evolve to meet patient requirements and system needs, but concludes that the status quo will do for foot care. It is incomprehensible to us how HPRAC identified serious shortcomings in Ontario's current foot care model, but concluded that Ontarians should be satisfied with the 35-year-old chiropody model.

In one area alone, conversion to a podiatry model would have a very substantial and very positive impact. You know of the high rate of foot and lower limb amputations caused by Diabetic Foot Ulcers. The preponderance of these amputations need have happened had there been timely intervention by podiatrists as part of the interdisciplinary team. As you well know,

the highest incidence of amputations due to DFUs occurs in Northern Ontario and in Ontario's First Nations communities. Ontario has a higher incidence of amputations as a consequence of DFUs than Cuba! The documentation is extensive and clear pertaining to the role podiatrists can play as part of the interprofessional team in the prevention, diagnosis and treatment of diabetic foot conditions and in the prevention of amputations from Diabetic Foot Ulcers. You are doubtless aware of the figures cited by the Canadian Diabetic Association, namely that the treatment of diabetic foot ulcers cost Ontario's healthcare system $320 to $400 million in 2015, with indirect economic costs of between $35 million to $60 million. Data indicates that fully 85 percent of amputations arising from DFUs in Ontario are avoidable when patients have access to appropriate prevention and treatment. Removal of the podiatric cap to allow more podiatrists to practise in Ontario and an expanded scope of practice to allow us to participate more fully and effectively in the interprofessional diabetic team will help to significantly reduce the number of amputations and significantly reduce the direct healthcare costs and indirect economic costs.

No point is served by critiquing the HPRAC report at this time. It is replete with misapprehensions concerning the proposal to transition to a podiatry model. Substantial errors and omissions permeate the report. At least some of these failings could have been corrected if HPRAC had agreed to meet with the OPMA. It remains incomprehensible to us why HPRAC refused to meet with the sole association representing the podiatry profession in Ontario. We do, however, appreciate the time and attention your Senior Policy Advisor, Ian Chesney, has granted us.

Every jurisdiction that has launched an expansion of the podiatry scope of practice first encountered strong opposition from orthopedic surgeons. In its report, HPRAC has apparently succumbed to the foot care model put forward by the Ontario and Canadian societies for orthopedic surgeons. That is the same model that was presented to the Ministry of Health and Long-Term Care by the same societies in 2009, based on 2003 data. Nonetheless, the OPMA and its members have no interest in competing with and certainly not supplanting orthopedic surgeons. Podiatrists are not orthopedic surgeons and do not aspire to be orthopedic surgeons any more than performing a skin graft makes one a plastic surgeon, or trimming a plantar wart makes one a dermatologist. Podiatrists provide a continuum of care from prevention through to surgery. Orthopedic surgeons perform surgery. What the podiatry profession aspires to in Ontario is a relationship with orthopedic surgeons analogous to the established and very efficient relationship that exists between obstetricians/gynecologists and urologists. Podiatrists fully recognize the range and type of surgical procedures that must be referred to GPs and medical specialists, that are best performed by orthopedic surgeons in hospitals, or that must be referred to vascular surgeons or dermatologists.

Having drawn valuable insights from the HPRAC process and report, in particular from stakeholders' comments and suggestions, we should like to highlight our vision for the future of foot care in Ontario that truly does put patients first:

- We acknowledge and accept the feedback from many stakeholders and HPRAC's recommendation that, in the interests of transparency and clarity, there should be some distinction between general practice podiatrists and "podiatric surgeons" (for lack of a better term for now) within a newly-named podiatry profession. For that reason, we propose the creation of a specialty within the newly-formed podiatry profession. The

specialty would be populated by current members of the podiatrist class, current chiropodists who have Doctor of Podiatric Medicine degrees and equivalents and those who are subsequently registered and have the competencies to perform surgical procedures on the bones of the foot and ankle. This is an analogous to (for example) the specialty of oral and maxillofacial surgeons within the dentistry profession or the extended class (Nurse Practitioners) within Registered Nurses.

- In light of HPRAC's and stakeholders' comments and suggestions, members of the specialty would provide the continuum of care currently authorized under the *Chiropody Act*, but in addition would provide the additional or expanded authorized acts recommended by the College (namely setting or casting a fracture or dislocation of a joint, administering or ordering the administration of forms of energy, ordering laboratory tests and injecting substances in areas of the body in addition to the foot). The PES report commissioned by the College confirms that members of the podiatrist class and DPM chiropodists have the competencies to perform these authorities and these authorities are authorized to our peers in Alberta, British Columbia and across North America. This reform would allow practitioners to provide a more extensive and seamless continuum of foot and ankle care to patients, without net additional costs – and the realistic prospect of savings – to Ontario's health care system.

- The podiatric cap must be removed. Removal of the cap will allow the specialty to grow in response to patient demand and, not incidentally, will allow the remainder of the profession to evolve naturally as it has been allowed to do in other jurisdictions and as all other health care professions have been allowed to do in Ontario.

The OPMA wishes to make it as clear as possible that it is unalterably and strongly opposed to implementation of HPRAC's recommendations as they stand. Simply changing the name of the profession accomplishes nothing for patients. Chiropodists would still be practising within the anachronistic, limited and orphaned chiropody model, but would be able to call themselves podiatrists. A name change without a scope change will add to, not reduce, confusion amongst the public, patients and other professions. The OPMA supported a name change for the profession, but only in the context of a scope of practice change process to a podiatry model. The OPMA and the Canadian Podiatric cap medical Association will commit all the resources we have to resist a name-change-only initiative.

In closing, we acknowledge that the chiropody and podiatry professions combined are small in the scheme of things, about 2% of all regulated healthcare professionals in Ontario. But the size of the professions has been entirely due to 35-year-old government policies, not the absence of patient or system demand and is never matched the contribution we could make to foot care if our potential was let loose. In many ways the current status of the professions is a self-fulfilling prophecy created by government policy.

We have also been told by Ministry officials that a scope of practice change is "not a priority" for the professions and something that will not be considered during the current mandate of the Wynne government. We are also aware that other professions claim that they can respond to the foot care needs of Ontarians. But those mistakes have been made before and the chiropody and podiatry professions are the only regulated professions that specialize in the foot and ankle.

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Accordingly, Dr. Hoskins, you have been presented with a once-in-a-generation opportunity to correct a long-standing public policy mistake by reforming Ontario's foot care delivery model so that patients are really put first. We urge you to do so.

Thank you for your consideration. I would very much appreciate the opportunity to meet with you to talk about how the proposals we have made can substantially improve patient care and patient satisfaction.

Yours sincerely,

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