

Perspectives, a VLRC Podcast

Episode 2 Transcript

Host: Jennifer Urosevic, President and CEO, Vision Loss Rehabilitation Canada

Guest: Dr. Nina Ahuja, Ophthalmic Surgeon and President, Canadian Ophthalmological Society

Narrator [00:01]

This is Perspectives, a VLRC podcast.

Dr. Nina Ahuja [00:05]

We are often taking our vision for granted, and until you have a problem with your sight, you don't realize just how precious it is.

[Theme music] [00:12]

Jennifer Urosevic [00:14]

Welcome back to Perspectives, a VLRC podcast. I'm Jennifer Urosevic, President and CEO of Vision Loss Rehabilitation Canada. VLRC has created this series as part of an eight-part collaboration with the Vision Health Partners Coalition on the National Strategy for Eye Care. Today's episode: When Diagnosis Leads to Treatment. We're looking at what happens after someone is diagnosed with a condition that needs specialist medical or surgical care. My guest today is Dr. Nina Ahuja. She is an ophthalmic surgeon, a clinical professor at the Department of Surgery at McMaster University, and President of the Canadian Ophthalmological Society. Nina has spent over two decades in the operating room and medical education, and she's been the national voice advocating to help bring the national strategy to life. If you've ever wondered what actually happens once you're referred to a specialist, or why timely access to that care matters so much, this conversation is for you. Each episode in this series contains the national strategy for eye care. Today's conversation is focused on two pillars: equitable access, and integration into the health care system. Nina, thanks so much for joining us today.

Dr. Nina Ahuja [01:28]

Thank you, Jennifer, for having me. It's a real privilege to be here, and also thank you for creating this wonderful series.

Jennifer Urosevic [01:35]

No problem. We're really excited to start this conversation. You've got such a wealth of experience, from being an ophthalmologist, to being President of the Canadian Ophthalmological Society, to being a clinical professor, really educating the next generation of ophthalmologists. How do these three areas help you and inform each other?

Dr. Nina Ahuja [01:59]

Well, the advantage of being in clinical practice is you really get to see the front line and how things work, how patients present, the systems within which we're working, where the limitations are, where the strengths are, and where we can make things better. Having the educational background as a professor at McMaster has given me a lens over time where I've learned to look at the evidence. Where do we need to look at data? How do we bring together different perspectives to make sure that we're looking at all the factors that need to be included when we're looking at the best way to move something forward? When it comes to my role at the Canadian Ophthalmological Society as advocacy chair, which is the role I was in prior to becoming president, the big advantage there was having that 20,000-foot view of the system within which we work, and how things can be moved through a system to bring about initiatives, programs and collaborations that can move eye care forward collectively with our partners across the vision health spectrum. So bringing those three elements together, frontline experience and exposure, together with the academic lens of the evidence-based approach, and then having that 20,000-foot view, is really able to build a comprehensive approach, in my mind, when we're thinking about some of the challenges and strategies that we want to bring forward.

Jennifer Urosevic [03:28]

Love that. I think that really resonates, and I think that's been the success of the advocacy that the Vision Health Partners Coalition has achieved. We all bring a piece of the full continuum of health care. But we also bring, like myself and like yourself, that clinical frontline perspective to the bigger picture, and then being able to look at how we create change from a system perspective. So now I just want to dive back into the early days. What got you to pursue a career in ophthalmology?

Dr. Nina Ahuja [04:05]

For me, ever since I was a child, eyes were the first thing that I noticed about people. I don't know what it was, but I loved looking at the different colours. Some people had smiles in their eyes, and other people just looked off into the distance like they were thinking. So I always enjoyed that. And then as I was

moving through school, I used to enjoy science. I loved learning about the senses, and I myself needed glasses from the age of about 13. So it became kind of a personal thing. I recognized that I couldn't see the blackboard in class, and therefore my parents took me to an optometrist. I was prescribed glasses, and that fixed the problem. As I moved through school, I continued my interest in science and biology, and I was drawn to health care. I enjoy working with people. I enjoy helping people. Medicine was a nice blend of science and helping people and physiology and all the other things that come with it, so I was very drawn to that field. But again, I always had that interest in eyes. So at one point, I was very serious about optometry. And then I felt that I wanted to do different types of care. Optometry was essential. It was extremely interesting. It's extremely valuable, of course. But I wasn't sure if I wanted to focus in on the field of eyes. And so when I got into medicine, I was certainly drawn right back to it. So it became a bit of a full circle moment for me as I went through medical school and discovered some of the procedures and innovations that were coming out in that field.

Jennifer Urosevic [05:44]

That's incredible. It's amazing what a young child's dreams turn into. What an incredible career. And then as you moved through your career and chose your specialty in ophthalmology, you were really able to expand into some leadership opportunities as well. Take me through what drew you to those leadership opportunities.

Dr. Nina Ahuja [06:06]

I was very fortunate. When I started in practice in Hamilton in 2003, I had joined a group, and it was affiliated with McMaster University in Hamilton. They had not re-established an ophthalmology residency program. They used to have one a while back, and then it had stopped. It was discontinued. And people like Dr. John Harvey and others were very motivated to bring this training program back to McMaster University. That happened within the first couple of years of my joining the department, and so I was brought in to faculty to help develop the program. I've always wanted to support students, and therefore I took on that role and then progressed through various roles as well. What got me into the leadership space specifically, beyond doing the leadership, was when I saw various leaders in health care doing their very best, some creating excellent environments where people felt seen and heard, they were thriving, they felt connected, and others, unfortunately, despite the best of their abilities, creating environments that were very toxic. When I saw that, and saw that there wasn't accountability in many of those instances within the system, I became very frustrated, and I thought, I need to do something about this. That's where I

stepped into the leadership development space, and went to various business schools and did various programs to develop an expertise in that, which has since evolved into emotional intelligence and rewiring for mental performance, and a whole approach to leadership development that isn't tactical specifically. It uses those strategies, but it also goes into who we are as people. How do we view the world? How do we interact with it, and how does that impact our leadership? So it was really an evolution that stemmed from observations and experience, both on the side of being a leader and of being led, because you're always in those situations. And then seeing an overall perspective of how we can make things better, so that people in our organizations, in our education systems, and wherever we are can really thrive in those environments and feel uplifted.

Jennifer Urosevic [08:25]

That really resonates with me, Nina. What I really like about that is that at each step in your career pathway, you witnessed things, then you responded to the need. And I know from our experience working together over the last few years around the national strategy, that really came out in a lot of our work. So I've always appreciated that about the work that you do. Thank you for that.

Dr. Nina Ahuja [08:51]

Well, thank you for that. That means a lot to me.

Jennifer Urosevic [08:55]

For our listeners who are not familiar with the profession of ophthalmology, what does an ophthalmologist's day-to-day look like? How much time is in clinic, because you mentioned being in clinic, and how much is actually in surgery?

Dr. Nina Ahuja [09:07]

Well, the day-to-day of an ophthalmologist can be quite varied. It depends on where you're located. If you have an office within the community, it will look one way. If you're in an academic centre, it will look another way. The academic centres are the universities where we have the training programs, where ophthalmologists who are up and coming are learning the skills surgically, clinically, diagnostically and procedurally, all the things that we do to become specialists. The way that it works is, to become an ophthalmologist, you do your undergraduate degree, then your medical school degree, which is four years. After earning your MD, you get into a residency training program, and by the end of those five years, you become a comprehensive ophthalmologist. Many will then go on to do an additional year or two to further subspecialize. So if you're based out of one of those centres, your days often start with teaching in the mornings, where faculty members are educating fellow faculty members,

because we're all about continuing education all the time, and then of course the medical trainees. Through the day, you'll be spending time in clinic, where you're seeing patients, assessing patients, and working with the medical trainees, who are the residents. So they're ophthalmology residents, going through cases with them, going through diagnostics with them, going through the gamut of: What are the medical conditions that are impacting this patient's care? What are the different perspectives that we need to keep in mind, based on these medical conditions, based on the treatments that they've had, based on their history? So we go through that. It's a very educational space; that is the theme across the academic centres. And the pace is very different depending on the clinic and depending on the ophthalmologist, because those centres often get the hardest cases, the most complex cases. That's where our tertiary care providers are, which means the specialists of the specialists are often located at the academic centres. Now, in a community base, there are also many specialists of the specialists. We have excellent ophthalmologists in the community as well. We're very fortunate that everyone across the country has passed exams, has gone through accredited training for five years, and has passed credentialing exams through the Royal College of Physicians and Surgeons of Canada. We're overseen by regulatory bodies in each province. So the confidence and trust that people can have in ophthalmologists is very standardized across the board. In a community, people will be more or less focused within a subspecialty, depending on what their interest was as they were going through their studies, and also depending on what the need is. So, as an example, if you're in an urban centre, where you've got potentially relatively more ophthalmologists, you may have people focusing in on certain areas, with a lot of collaboration amongst the ophthalmologists and with our optometry partners as well. Whereas if you're in more of a remote or rural area, you may have an ophthalmologist who, because there aren't as many subspecialists, does the gamut of work across the different specialties, and if it gets to a point that's very advanced, then they would send it off to a subspecialist in a larger centre, if it's needed. So in those days, you arrive at work, you go through your patient list to see who's coming, and patients come through. We work in teams, so we often have ophthalmic technicians working with us. Some people have nurses working in the office, and other people have our optometry partners working in the office. And depending on what the flow is and how the office or practice has been set up, the patient will then go through various steps along the way: an initial assessment, some diagnostic testing, and an assessment by the specialist to really look at the condition for which they were referred. And then the day just carries on that way, in the same routine, adjusting to the needs of the patient who's sitting in front of you. Sometimes there's time for lunch, sometimes there's not. Most often it's a granola bar. That's not

everybody, but in my case, it was often just a quick bite here and there. It's a pretty intense, steady day, as many of our days are, for many people. But it's very fulfilling. What I found most fulfilling about being where I was at is that there was a nice mix of the clinical work with the academic work, and being able to work with learners and faculty as well. And I have always enjoyed patient care. My philosophy has been, I treat my patients the way I would want my parents treated. So it's a very fulfilling mix, intellectually, connection-wise, technically, and in overall satisfaction that you're helping people to the best of your ability.

Jennifer Urosevic [13:54]

I can hear so much passion in your voice as you describe the different scenarios. And I resonate back to a program that we have, the Eye Van, that travels through Northern Ontario. We couldn't run that program without our partners and the ophthalmologists who take a week out of their clinics and travel through Northern Ontario on, I always call it a van, but it's really a big transport truck. They become that generalist within their specialty, and make those connections and those referrals, and provide that treatment in some of our most rural areas here in Ontario.

Dr. Nina Ahuja [14:28]

I love that. One of the things I would like to share is that with Vision Loss Rehab Canada, there is such an important role there, and the engagement that we have with our partners across the spectrum is so valuable. I really appreciate the fact that we have organizations like yours, because when there is vision loss, there's still dignity in that, there's still potential in that, there's still opportunity in that. And for someone who's acquired vision loss, it's a complete shift in identity, in how they view themselves and what their place is in the world. So I just wanted to really acknowledge the work that you do, that your organization does, because it is truly such a valuable component of the entire spectrum of care.

Jennifer Urosevic [15:14]

Oh, thank you. We appreciate that. And it is about the whole continuum of care. Which conditions do you see most in an ophthalmology caseload, or with the patients that come to see you?

Dr. Nina Ahuja [15:25]

It really depends on the nature of an ophthalmologist's practice. There's the day-to-day practice that we have in our clinics, and there's the on-call service as well, which is for emergency eye care. When you're on call, you are working with a hospital, as an example, and cases come through the door, whether it be a retinal detachment, or a sudden rise in pressure for someone who's got

glaucoma, or there's been a car accident and someone's had a trauma to the eye. When you're on call, you see all of those things, and that's why the broad training and the depth of training become really valuable. In the practice itself, it often depends on how someone has focused their practice, and again, location. As I mentioned before, if you're in a more rural area, you have that comprehensive caseload, where you'll see glaucoma, cataracts, retinal disease, macular degeneration as an example, diabetic retinopathy as another example. Those fill your days. There's quite a lot of variety. The eye is a small organ, yet it is very complex, and there are multiple conditions that can happen that need attention and treatment. If you are focused in a subspecialty, however, if you're, say, a retina specialist, an oculoplastic surgeon or a glaucoma specialist, then while you're on call, you'll still be covering the gamut of cases, but in your office it will focus more on that area. So a retinal person would see more macular degeneration, diabetic retinopathy, some of the inherited diseases. All the things that affect the retina will be seen by a retina specialist. Similarly, cornea specialists, glaucoma specialists, and oculoplastics, those of us who deal with the eyelid, the tissues around the eye, and the things in the orbit, the socket where the eyeball sits. That's another area of specialty. So you've got your comprehensive aspect, which is covered while you're on call, and then depending on your practice, you're either comprehensive or more targeted to one or the other.

Jennifer Urosevic [17:29]

That makes a lot of sense. So now, what would somebody expect in an appointment if they were seeing an ophthalmologist for one of those eye conditions? They're probably nervous because they have a diagnosis. What are those next steps, and what advice do you have for somebody coming in, maybe for the first time?

Dr. Nina Ahuja [17:52]

The first thing I would say to someone coming in for the first time is, you can trust the process and the education and training that your specialist has. Because we're medical doctors and specialists, we get referrals from optometrists, who are our primary eye care partners, family doctors, who are our primary health partners for general health, and some nurse practitioners as well. So we get information from the person who's referring to us. We review everything that's been provided and understand what you're seeing us for. And then when you're being assessed, we're targeting our questions, examinations and testing to make sure that we are addressing the issue that you've been brought to us for. At that point, there are a number of people in the team, as I was saying. So depending on what stage you are at in the patient flow through the office, you may see the

receptionist first, to welcome you and check you in. Then you may see the technician, and then you'll see myself as the ophthalmologist, in my office as an example. From there, we'll talk about your experience, what your concerns are, and what I see on examination, based on what you've said, and based on the breadth of experience and knowledge that I've accumulated over the years, through my training as well as experience over whatever time I've been in practice. In my case, that's over two decades. And then we'll talk about what the implications are of what I'm finding. Some eye conditions progress gradually. Others are more urgent, in that you need to do something. So we'll have conversations around that, talk about the options, and then make plans from there for follow-up, and potentially bringing in other partners: referring to a subspecialist, as an example, since I am a comprehensive ophthalmologist, or co-managing with optometry if everything is stable and we can work together with our partners there. So it really is case-dependent, but that's typically what you can expect when you go to an office.

Jennifer Urosevic [19:51]

Thank you for that. We're going to get into timely access and wait times in a few minutes, which I know is so critical with some of the advocacy we've done around the national eye care strategy. Is there a moment in your career that stands out as a reminder of why timely access matters so much?

Dr. Nina Ahuja [20:12]

Yes. I actually had a patient who was having gradual vision loss and had been seen several times, but there wasn't anything obvious. Their vision started to decrease further, and they were referred to me. When I did some testing, because the medical history suggested that some testing was required, the lab studies actually showed that the red blood cell count was threateningly low. In fact, what was happening is the red blood cells, which carry oxygen to the different tissues in the body, including the eyes, were so low that the eyes weren't getting enough oxygen. So the vision was fluctuating and gradually going down, because the optic nerve, which is the cable between the eye and the brain that transmits our visual images to help us see, wasn't getting enough blood flow. Once we realized that, the person received blood transfusions, in partnership, of course, with our medical experts in internal medicine, and the vision recovered. But had that access not been there, which came through an on-call referral, it would have potentially resulted in permanent vision loss, and even worse, potentially loss of life, to be quite frank. Not to be dramatic about it, but this person was at risk not only for vision loss, but for a heart attack as well as stroke.

Jennifer Urosevic [21:38]

What a very impactful moment. Definitely. We're going to talk a little bit now about access, and I think the timeliness in your example of the most impactful surgical moment for you there is really critical. Where do you think wait times have the biggest outcome on somebody's health, and why?

Dr. Nina Ahuja [22:00]

When it comes to wait times, I think of it from the perspective of impact, because there are different types of impact when it comes to vision loss. There's the biological impact. For example, you can have an anatomical issue, like a retinal detachment. If it's not repaired immediately, you can have permanent vision loss. Similarly with glaucoma: if someone's pressure has suddenly spiked and you don't correct it, you're going to have permanent vision loss. So that's a physiological, biological, anatomical impact of wait times that are beyond what's ideal. The other side of it is the functional impact. For example, when people develop cataracts, for the most part, it's not something like a retinal detachment or a sudden increase in pressure like glaucoma, where you need to treat it immediately. Oftentimes people are diagnosed with cataracts, and we follow it along as ophthalmologists in partnership with our optometry colleagues. Once it gets to a point where it's affecting vision and affecting the ability to do things well, then that's an impact that becomes important as well. So when you're looking at wait times for the emergent cases, where there's an anatomical shift that can cause permanent vision loss, wait times that are long can have devastating consequences. Now, the benefit that we have is the on-call service that ophthalmology provides at hospitals, so that if someone has something like that, they can go to the emergency department. We get a referral directly from the emergency doctor, and then we take it from there and do what we need to do. Not all cases can have restored sight, but depending on the nature of the case, we can at least assess it and do what we can. From a functional standpoint, cataracts, like I said, can develop slowly over time, so the wait times are a little more tolerable. I say that very guardedly, though, because when vision gets worse, you're at increased risk of falls, as an example. You can become less functional at work. You can become dangerous at work. So we need to be able to address those wait times. There's no question about it. But I do see a difference in terms of where we need to make sure that it's tight, and we're lucky we have that with our on-call services for the more emergent cases, so that we can then try to address the other issue, where we can keep people functioning as well as possible from a vision standpoint, in terms of decreasing risks of falls and all the other safety issues, and maintaining their engagement in the surrounding world that they're in, so they can enjoy it as best as they can.

Jennifer Urosevic [24:42]

Yeah, it sounds like triaging: looking at the cases that are the most emergent and critical, which are the most important ones to get early, quick access to, but also really monitoring and understanding where vision is starting to impact daily living, which increases somebody's access need as well.

Dr. Nina Ahuja [25:03]

And I'm certainly not minimizing that second category. Ideally, everybody gets care as quickly as possible: right person, right provider, right time. But in the reality that we live in, that's how we need to look at it at this point, until we figure out how to make the system function more effectively that way, to meet the needs.

Jennifer Urosevic [25:22]

No, I think that makes a lot of sense. So we've talked about wait times. If we flip to the word access, do you see a difference across Canada between an urban centre and a rural or remote area, in access to ophthalmology?

Dr. Nina Ahuja [25:39]

There are differences. At the Canadian Ophthalmological Society, some of our members have done studies looking at the geographic distribution of ophthalmologists relative to the population. We do see that a good percentage of patients are within a certain distance of ophthalmologists, which is reassuring, but some of these distances are far, and so travel can become an issue. In a lot of these rural centres, we don't have a large number of ophthalmologists, so there are fewer providers there. So travel does become a barrier sometimes, if people can't make it to a larger centre. And then also, when they do come and you're able to provide care, the follow-up of care becomes a concern as well. So there are differences. With the Canadian Ophthalmological Society, and as we're doing through the Vision Health Coalition, a primary priority is increasing access to care. That's where we're trying to leverage different technologies, exploring how we can have collaborations amongst our professional colleagues along the spectrum, all the way from prevention through to rehab, and what we can do to help people get the best care at the right time, regardless of whether they're urban or rural. But there are some challenges, for sure. There are differences.

Jennifer Urosevic [27:02]

So now I'm going to give you a little magic wand, Nina. If you could wave your magic wand, what would it take to reduce wait times across Canada?

Dr. Nina Ahuja [27:14]

I would say number one is to optimize our existing resources by really having integrated care pathways that are developed in partnership between optometry and ophthalmology, so that we can make sure the limited financial resources are used most effectively, in the best interest of our patients. I know that we have a common goal there, so I'm very hopeful and optimistic that we will get to be working together on that. I think prevention is huge. I think that's where Fighting Blindness Canada is very important. We've got so many things that we can be doing to increase research, to understand the contributing factors to eye disease that we can prevent, or that we can educate people on. So that is also something that is very valuable. And the third thing is to have a commitment from the government to really look at what resources are being allocated, and how more can be allocated as well. Because vision is important. There are huge economic losses associated with vision loss. Some data shows that for every dollar invested in eye care, you're getting \$3 back in terms of productivity and return. So if we look at those three aspects, we can really try to use our resources as effectively and efficiently as possible, so that we can have more care, more programs and more initiatives to really bring care to everyone in a way that's going to benefit them, so that vision is preserved, optimized and enhanced as best as possible for the population.

Jennifer Urosevic [28:57]

I love that. Thank you for that. Maybe this is another area where there's been a lot of advancement, around treatment and innovation. What do you see as the most exciting, or what are you most encouraged about, related to some of the major eye conditions that are affecting Canadians today?

Dr. Nina Ahuja [29:22]

Well, I think there are many things happening right now, but the one that I'll highlight is that we know that over the age of 55, macular degeneration is one of the leading causes of vision loss, and there are a lot of really exciting developments in that area. We do have injectable therapies, as an example, to treat wet macular degeneration. If it's caught early enough, sometimes you can preserve the sight. Sometimes you can even get a little bit of improvement. So that's really encouraging, especially since we know that that's the most common cause of vision loss in that age group, and we've got many people increasingly over the age of 55. I'm almost there too. But anyway, you've got your injectable therapies as one modality. The other thing that's really exciting is gene therapy, where they're discovering that there are certain ways to deliver healthy genes that otherwise are causing inherited eye disease. And that's again in the retinal space. So the research in that area is really expanding, which is again very, very

exciting. So where you have those categories of irreversible vision loss, there are developments happening that are really coming to the forefront to make a real difference for people. And then in surgical spaces, with cataract surgery, we've now got very small incisions, whereas before they used to be very large, which would impact recovery time, healing, and time off work for those people who are still working. And with glaucoma, as an example, we've got treatments that are not very invasive, and yet very effective. So we're seeing growth, development and research in all of these areas. Those are just a few examples.

Jennifer Urosevic [31:06]

So this one's always a hard question, because we don't know what we don't know today. But if you were to look five years in advance, what do you think eye care would look like that it doesn't look like today?

Dr. Nina Ahuja [31:21]

I'm very hopeful that eye care is going to be optimizing technology, expertise and efficiencies, so that patients are able to access care no matter where they are, and preserve and maintain their vision longer than we've been able to so far. To get a little more specific on that, we know that there are technologies that allow us to do remote access to care, such as teleophthalmology. Artificial intelligence is coming into the space, and that's going to be allowing for diagnostics. That is going to be a very efficient use of resources once we've validated a lot of the algorithms. Initially, it's going to be a lot of extra work, I think, because while it can do a lot to help identify diseases, we need to make sure that it's accurate, and so there's a lot of expertise that needs to be involved in that validation. But remote access to care through teleophthalmology, as an example, and AI algorithms, and how we can use them to optimize care, allow us to care for more patients once we have that optimization and efficiency in place and everything's been validated. And then the integration of care, where we're really optimizing the expertise along the continuum, again, from prevention: What's the research coming out? How can we inform and educate people in terms of maintaining and preserving their vision? How can optometry, how can we increase access to routine eye exams for children all the way through to seniors, and how can we optimize resources so all of that can be funded? And then with ophthalmology, how can we leverage the expertise that we have in the medical and surgical space to really be able to preserve vision where we can, and then restore vision where we can, and hopefully have more tools? And then from there into the vision rehabilitation and low vision space, with organizations like yours, where we can really help people still be productive and contributing in ways that are meaningful to them, while potentially having to deal with this challenge. So I see

this lovely tapestry of care, where all of us are doing our parts, and yet we're all intertwined in ways that it just flows. That's what I would love to see.

Jennifer Urosevic [33:31]

I think that's a great five-year view of what eye care looks like, and I think we're going to get there with this national eye care strategy. At least I hope so. You and I had the privilege of doing a lot of advocacy work together, and we both had the opportunity to present at the Senate. What did that process teach you about health policy and how it really gets made?

Dr. Nina Ahuja [33:58]

That was a fascinating experience for me. I so enjoyed that, and I felt so honoured to be a part of that process with COS and working with all of our partners. I was able to get involved, learn everything, get engaged, and help bring it across the finish line with our entire coalition. What was not seen, though, in those moments, is the years of work and effort that were put in by my colleagues at the COS, colleagues at the Canadian Association of Optometrists, yourself, and all the organizations that are involved in the coalition. So the lessons from that experience for me were a few. One: introducing health policy or making a change is a long process. It requires patience. It requires diligence, coordination, collaboration and communication. It's very much an integrated process that you need to be committed to, to be able to bring it to a point where it can be passed through the finish line. There were champions within government. Judy Sgro, she was the MP who brought this forward as a private member's bill. So fortunate to have that voice being lent to this cause. And then Senator Ravalia, he was in the Senate. He was really pushing it and supporting it as well. So that, to me, became part of that collaborative piece, where you need to have the key stakeholders who are believing in this mission and believing in the vision working together, and then key people who are in and around those decision-making tables to really bring voice and lend voice to this. It was fascinating. The other thing I would say is I was really happy to see the due diligence that was put forward in both the House and the Senate. They were really looking at the legislation to make sure that it was robust and well thought out, and that there was something really substantial behind it. So to me, that's reassuring: when it comes to bringing about change in government, it is a thoughtful process that we can, again, have trust in.

Jennifer Urosevic [36:16]

Yeah, I agree. That really resonated with me as well. So COS represents over a thousand ophthalmologists across the country. How do you build consensus among so many practices and perspectives, while advocating with one voice?

Dr. Nina Ahuja [36:29]

The best place to start, from my perspective, is: what is the ultimate common goal? That common goal and shared perspective is that we want to deliver the best quality of care to all Canadians. And with that, what does that then require? That requires excellent standards of care. That requires us to be accountable for the care we provide. That requires systems that are there to ensure that we're regulated, that the standards are being met, and that there are checks and balances within the system. Recognizing that people have different perspectives, though, and different practice styles, and we've got many changes happening within the world of ophthalmology that will bring us forward in many respects. Not everybody agrees on how things should be done, even though we have that common goal. So my approach has always been, let's focus on what the ultimate is, and then whatever differences we have, let's learn from each other and understand what the perspectives are. What are the lessons you've learned from your experience? What are the lessons the other person has learned from their experience? What do I bring to the table from my experience? As you mentioned earlier, I've got an academic lens, I've got a leadership lens, I've got a clinical lens. Other people have an entrepreneurial lens in the ophthalmology space. Those are the experiences we bring from the totality of experience that each one of us has. And so if you're open to asking questions and seeing, okay, now what is common within that, that can benefit that ultimate goal, that becomes a process by which we can then come forward with a united voice.

Jennifer Urosevic [38:05]

With the implementation of the National Strategy for Eye Care, and it being tabled in June, what happens next? What do you believe the government needs to do so that Canadians feel the benefits of this national strategy?

Dr. Nina Ahuja [38:19]

I think the most valuable thing that the government can do is really put support behind this effort, so that the national strategy is actually implemented. I agree with you that if it is tabled as a document, that's an amazing first step, but it does nothing until it goes through to implementation. So our joint ask is to request funding so we can establish a National Vision Health Steering Committee, which can basically oversee the various parts of the strategy and help ensure that things are implemented, because there are so many different elements to the strategy itself. We've got the various priorities, from access through to data collection and so on. So I think that would be the big thing. And also the recognition that vision matters. We are often taking our vision for granted, and until you have a problem with your sight, you don't realize just how precious it is.

So I think supporting implementation of this strategy is the biggest thing that the government can do.

Jennifer Urosevic [39:26]

Yeah, I agree. And I think without having that accountability, sometimes strategies like this just stay on a bookshelf, and that's not what we want the National Strategy for Eye Care to be. I think you laid out a really important point there at the end: we want people to be aware that their vision matters, not just when something goes wrong, but to be proactive. So prevention, and making sure that people get out and get their eyes tested on a regular basis, is so critical as well.

Dr. Nina Ahuja [39:59]

Yes, I agree 100%.

Jennifer Urosevic [40:01]

So you've written and spoken a lot about stress, resilience and respect in leadership and in medicine. How do those ideas shape the way that you lead COS, and even run your own clinic?

Dr. Nina Ahuja [40:15]

For me, one of the fundamental principles in my work in leadership, and in the leadership model that I've developed, is really recognizing that everybody views the world through their own lens. We all have experiences in our lives, and each experience in our life leaves a crack on a windshield. I often speak of that analogy. The lens through which you view that windshield is going to impact how you view the world, how you receive it, and how you interact with it. So my approach to leadership at the COS, and in general, really respects that, because while we may not agree, it's worth hearing another person's perspective. Everybody learns something from their experience, and if we're able to bring that experience to the table, we can develop solutions to challenges, or initiatives and opportunities that really have more depth, richness and comprehensiveness, if we're allowing people who have different viewpoints to add to the conversation. So I'm not one to shy away from conflict. That, I have to admit, has been an evolution, because generally I'm a non-conflict person. But I've learned to appreciate conflict, because it's very easy to agree with people, but it's very difficult to be open to hearing perspectives, and being receptive to those perspectives, when you're in disagreement. And yet sometimes I think that's when some of the most powerful insights come.

Jennifer Urosevic [41:52]

I love that. And I think that's one of the leading areas where, when we talked a few minutes ago about bringing the voices and perspectives of over a thousand ophthalmologists together, really leaning into that leadership and understanding where people are coming from, I'm sure, is building on the success that you're having at COS. If we talk a little bit about well-being, we know that the work that you do in ophthalmology, and in leadership as well, can be stressful and overwhelming. Is there a connection between a surgeon's own well-being and the quality of care that patients receive?

Dr. Nina Ahuja [42:35]

I would say that there is a connection between a surgeon and the care they deliver from an interaction standpoint, not from a quality of care standpoint. There are exceptions as well, so don't quote me on that directly as a blanket statement for 100% of people. But there are a couple of things that contribute to why I said what I said, that it's more often an interaction thing than a quality of care thing. Number one, our training is rigorous. Medical school is not easy. Residency is not easy. There are times when you're up 24 hours and then another 24 hours. That was not an uncommon experience. You are pressed and pressured. Your stamina is developed within an environment that is contained, in a space where you've got experts around you as your preceptors and supervisors. You're doing procedures, you're dealing with difficult cases, you're seeing the gamut, you're getting the feedback, you're dealing with trauma. You're dealing with the ups and downs and the emotional highs and lows of what it is to deal with someone with severe vision loss, or someone who's had a trauma where, unfortunately, the sequence of events is such that the eye needs to be removed. You are dealing with the most high-stakes, high-intensity moments in a sheltered space, to develop that capacity over an extended period. You're looking at at least nine years in an accredited space. So you can have the confidence that if you're faltering, the people there will be able to teach you and guide you through those moments. So that's number one: you have confidence in your training, and you build up the capacity for resilience in your training as well. Number two, we are all held accountable. There are accrediting bodies that we need to be approved and certified by before we can even get out there. And then in day-to-day practice, we have the regulatory bodies, where patients can put forward complaints if there's a concern, and those concerns are taken very seriously. That is an accountability piece that becomes very central to ensuring that we maintain our education, that we maintain our skills, and that we maintain personal checks and balances, to ask: Are we meeting the standards that we've been trained to meet? Are we safe in providing the care? And can we maintain that patient trust? So even where the stress can become very, very high, and you

can be pulled in different directions, we've been through so much that it becomes part of who you are. That level of excellence and commitment to patient care becomes who you are. That's why, no matter how stressed you are, I don't believe it translates into the quality of care. That said, sometimes, depending on how well you manage your stress, you may not have the best bedside manner, and that is actually part of quality of care. But when it comes to the technical aspects, I think for the most part, we're good to go. It's those interpersonal skills, how you communicate with people and the rest of it, that we don't get training in, and that's why that is sometimes a weak point. That led to me going into the leadership space and doing all the work that I do now.

Jennifer Urosevic [45:54]

I love how you've done that as a full circle again. You've shown another example of where you've witnessed different areas, and then invested your own time and your own expertise in learning an area that is so important. I would say it's very important in ophthalmology, but it's very important in any type of clinical leadership role, like you've described there. So one of my favourite questions that I want to ask you now is, if you had 30 seconds with the next Minister of Health, what is one thing about the National Strategy for Eye Care that you would want them to understand?

Dr. Nina Ahuja [46:35]

Vision is important. The strategy must be implemented. We're here to support you however we can. Just let us know what we can do. That's what I would say.

Jennifer Urosevic [46:44]

Wow. Very impactful. It's a great opportunity.

Dr. Nina Ahuja [46:48]

Yeah, it is. It's as simple as that.

Jennifer Urosevic [46:52]

Very good. So this series is launching on World Sight Day, October 8th. What does that day mean for you and for COS?

Dr. Nina Ahuja [47:01]

That day, to me, is really about celebrating vision as the gift that it is. When I take off my glasses, the world is a blur, and that started in childhood. So I recognize and appreciate the gift that vision really is. It's what allows me to do what I do, and I feel very blessed for that. So to me, it's representative of that. And I think for the organization, it's a recommitment to an ongoing commitment to really

protect vision for Canadians, and to bring the best of care that we can to all Canadians through the work that we do.

Jennifer Urosevic [47:40]

Beautiful. And my last question for you is, what is the moment or story that reminds you of why this work matters, even on the hard days?

Dr. Nina Ahuja [47:50]

I once had a patient who came into my office for a post-op check from cataract surgery, and she was crying. She was a lovely Italian woman, I think in her 80s, if I remember correctly, and she didn't speak English. Her daughter was with her, and I immediately was worried. I thought, my goodness, she's in a lot of pain, or something's happening. What's happening? So when her daughter translated, she said to me that she's crying because she's so happy. She saw her family portrait for the first time in 20 years because of her surgery. So those are the moments that make the really tough times worthwhile.

[Theme music begins and plays to the end] [48:30]

Jennifer Urosevic [48:31]

Absolutely. Well, thank you so much, Nina, for being here today, and to our listeners for tuning in to Perspectives, a VLRC podcast. Today's takeaway, I think, is an important one. The national eye care strategy is critical. We've got to move it from implementation into what really matters for Canadians. And the other piece that you really highlighted is timely access: as somebody's vision changes, that referral to specialists is so critical. You can learn more about the Canadian Ophthalmological Society at cos-sco.ca, and about VLRC's work at visionlossrehab.ca. If you're listening and enjoying this series, follow or subscribe wherever you're listening. It really helps us find more people in these conversations. Join us next week as we turn the lens on to VLRC, where we'll discuss vision rehabilitation, habilitation, independent living, and Vision Loss Canada's survey report. Until then, this has been Perspectives, a VLRC podcast. Thanks for listening.