



Ontario's Optometrists: Soon Prescribing TPAs?

Minister requests review

The Honourable George Smitherman, Minister of Health and Long-Term Care, has asked the Health Professions Regulatory Advisory Council (HPRAC) to review previous recommendations in relation to optometrists prescribing therapeutic pharmaceutical agents (TPAs). Specifically, the Minister has asked HPRAC to consider the currency of, and any additions to, their previous recommendations. When HPRAC last reviewed this issue in 2000, the recommendation was that prescribing TPAs should not be added to the scope of practice of optometry.

The College disagrees. "It is the College's position that it is in the public interest to authorize optometrists to prescribe TPAs," said Dr. Mark Teeple, president of the College. "Our members have the requisite knowledge, skill and judgment to use TPAs safely and effectively and should be authorized to prescribe therapeutic drugs within the scope of practice of optometry."

The College believes authorizing optometrists to prescribe TPAs would result in fewer referrals to other healthcare practitioners and hospital emergency rooms. In addition to providing more timely and effective care to patients, this would be a more efficient use of Ontario's healthcare dollars.

"Our members have the requisite knowledge, skill and judgment to use TPAs safely and effectively and should be authorized to prescribe therapeutic drugs within the scope of practice of optometry."

In an effort to ensure that HPRAC has the information needed to make an informed decision, the College has provided information to the Ontario Association of Optometrists for their written submission and will be ready to respond to HPRAC's document as soon as it is circulated.

HPRAC's role is to provide independent policy advice to the Minister of Health and Long-Term Care on matters related to the regulation of

health professions in Ontario. Once the consultation is concluded, HPRAC will submit a report to Minister Smitherman setting out its findings and recommendations. However, the Minister is under no obligation to accept the recommendations made by HPRAC.

Upcoming Events

Council Meeting

June 9, 2005
Waterloo, ON

CSAO Exam

May 28-June 2, 2005
Waterloo, ON

May 31-June 5, 2005
Montreal, QC

Jurisprudence Seminar and Examination

May 12-13, 2005
Waterloo, ON

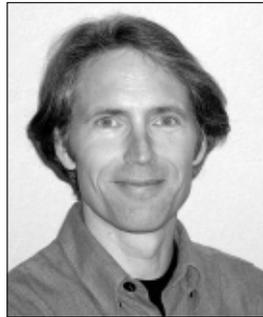
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A Word from the President

Hope, optimism and patience

Hope. That could be a word from the president, modified by “faint glimmer of...*hope*”. Or maybe “optimistic,” as in “cautiously ... *optimistic*.” Or perhaps the president’s word should be “patient” modified by “I know, we’ve all been... *patient* for a long time.”



Mark Teeple, O.D., President

I am speaking, of course, about the authority to use therapeutic pharmaceutical agents (TPAs) for the benefit of our patients in Ontario. The reason for cautious optimism is that the Minister of Health and Long-Term Care has asked the Health Professions Regulatory Advisory Council (HPRAC) to reconsider, among other issues, the matter of optometrists prescribing TPAs. Asking for a response by March 2006, the Minister has provided an aggressive timeline that will keep our College and professional Association, as well as other stakeholders, very busy in the coming year. The matter has obvious implications for public wellbeing, including accessibility to, and timeliness of, care.

Optometrists are an under-utilized resource of healthcare providers. We have the ability to improve patient access to care and reduce costs to the healthcare system. Many of our members already have the knowledge, skill and judgment required to prescribe TPAs. When the dream becomes a reality, Council will have several decisions to consider. The Registration Committee will be asked to recommend entry to practice requirements for TPA certification, and the Quality Assurance Committee will be asked what changes to the continuing education program should be made to ensure continuing competence. These are decisions that we have all patiently anticipated. Let’s hope that these decisions aren’t delayed any longer!

Working toward strategic goals

In the February issue of the Bulletin, members received a copy of the College’s revised Strategic Plan. I am personally quite pleased with the document that Council accepted. There are many goals and many more objectives identified in the Strategic Plan. Thankfully, it is

not my intention to detail each of these, but I would like to make a few comments about particular issues.

Qualifications and competence of members is each regulatory college’s *raison d’être* and the College of Optometrists is no different. In fact, our profession has been proactive in assisting members through the publication of written standards of practice, through the work of the Quality Assurance Committee, and through the work of the Appraisal Committee going back to the days of the Health Discipline Act. I am confident that this helping attitude will continue to permeate all that the College does. I have always believed that providing ‘excellence in optometric care’ is not only good for the public, but the best approach for the advancement of the profession.

Other initiatives in the Strategic Plan relate to recognition and awareness – both internal and external to the profession. You can expect to see the College increase its profile in the eyes of the public. But the public is not our only target in this area. One of the goals identified by Council is to “have members view the College positively and as being helpful”. Without your recognition and awareness of what the College does and why, Council and its Committees will have a much more difficult time doing what is needed.

Along the line of recognition and awareness, I would like to ‘introduce’ your 2005-2006 Council, the public face of the College. The professional members from across the province are Dr. Michèle Martin (Ottawa); Dr. Paul Monk (Gravenhurst); Dr. Mike Cobean (North Bay); Dr. Lorne Berman (Toronto); Dr. Debby Lowy (Toronto); Dr. Jim Wilkinson (Kitchener); and Dr. David White, our past-president (London). Dr. Bill Bobier is the University of Waterloo School of Optometry representative to Council. Public members appointed by the Lieutenant-Governor-in-Council are Mr. James Lexovsky (Toronto); Ms. Nathalie Pardy (Oshawa); Mr. Charles Korman (Toronto); Mr. Henry Hodowany (Toronto); Ms. Mary Jane Lenihan (Manitoulin); Mr. Graham Coveney (St. Catharines); and Mr. Craig Bridges (North Bay). Dr. Linda Bathe from Stratford is the vice-president and I, Mark Teeple, from the wilds of rural southwestern Ontario, am the president.

I urge you to contact me, Linda, or any of the Councillors with your questions, comments or suggestions. You will find that the professional members of Council share many of your concerns about the pressures of practice. My e-mail address is president@collegeoptom.on.ca. Complete College contact information, including staff email, is available on our website at www.collegeoptom.on.ca.

Hopefully,
Mark Teeple, O.D.

Registrar's Report

What does a referral to HPRAC mean?

By now, most optometrists will be aware that the Minister of Health and Long-Term Care has made a referral to the Health Professions Regulatory Advisory Council. HPRAC is a lay body established to provide advice to the Minister. Its mandate extends to health profession issues relating to:



Murray J. Turnour, O.D., Registrar

- (i) whether professions should become regulated;
- (ii) whether regulated professions should be de-regulated;
- (iii) amendments to the *Regulated Health Professions Act*, a profession specific act such as the *Optometry Act*, or to the regulations;
- (iv) matters concerning the Colleges' quality assurance programs; and
- (v) any matter referred by the Minister.

The Minister's recent referral to HPRAC is broad and includes a number of different issues. So, what should we expect after all is said and done? Is it likely that HPRAC's advice to the Minister will affect the delivery of care to patients? If so, how will patient care be affected? And when? These are some good questions. Let's take a closer look at the referral.

In his letter to Ms. Barbara Sullivan, Chair of HPRAC, Minister Smitherman actually made 13 separate referrals. Some of these relate to the *Regulated Health Professions Act*, others relate to professions that are currently regulated, and still others relate to currently unregulated professions. Optometry's referral relating to the currency of and additions to HPRAC's previous advice concerning prescribing drugs is one of the 13 referrals.

The Ontario Association of Optometrists has been invited to make a proposal to HPRAC as to what drugs it thinks optometrists should be allowed to prescribe and why. The College and other optometric stakeholders will be invited to provide their comments on the OAO proposal. Some of the reasons that will no doubt be mentioned will include improved access to care, the effectiveness and safety record of other jurisdictions where optometrists have been

prescribing, and reduced costs to the government healthcare system. These are the arguments that have been used successfully in the vast majority of other jurisdictions in North America. They are also the reasons that Ontario optometrists have presented in the past. Will they be enough to convince HPRAC and the government to expand the scope of practice now?

HPRAC is committed to an open and transparent process. Optometric organizations and other stakeholders will be invited to comment. It is too early to tell how all of the other stakeholders will respond to the OAO proposal; we will find that out later in the consultation process. We can only hope that optometry's arguments in favour of TPAs will carry the day in Ontario.

But what about the other 12 referrals? Will they affect patient care? One of those referrals relates to opticians performing refractions and whether dispensing eyeglasses should remain a controlled act. Some of the arguments that optometry will be using to (hopefully) obtain TPA prescribing privileges can also be used to support an expansion of the scope of practice for opticians. If these arguments are accepted in the TPA referral, can HPRAC reject those same arguments in the optician-refraction referral?

Other referrals that the College will be involved with include reconsideration of advice given about the *Regulated Health Professions Act*, the Complaints and Discipline processes, and the Quality Assurance and the Patient Relations programs. While these referrals will not have a direct impact on the care that patients receive from optometrists, they may affect the way the College interacts with members and the public. For instance, it is expected that the role of complainants in the complaints and discipline process will be reviewed, as will best practices for quality assurance programs and how Colleges communicate to members about issues relating to the prevention of sexual abuse of patients. Perhaps most important, the whole issue of self-governance – the concept of allowing members of the professions regulate themselves – may be reconsidered.

There is a lot at stake in these referrals. There is much to win and much to lose. The Minister has asked HPRAC for recommendations before April 2006. To meet this deadline, HPRAC has set aggressive timeframes for input from stakeholders. From this vantage point, one thing is for sure – the summer of '05 will not be one for relaxation.

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

Practice Advisory

Prevention of Sexual Abuse in Optometric Practice

In January 2005, Council adopted the following Practice Advisory on the prevention of sexual abuse. It is being published for the membership and other stakeholders so that there can be no mistake about the College's position on this issue. Members should read and adopt the recommendations outlined in the Advisory.

Introduction

The College of Optometrists of Ontario views any form of abuse of a patient, whether sexual or otherwise, as professional misconduct that will not be tolerated. The *Regulated Health Professions Act, 1991 (RHPA)* and the Health Professions Procedural Code (the Code) set out specific requirements for the manner in which the College deals with sexual abuse and provides severe sanctions for members who are found to have sexually abused a patient. This advisory sets out the legislated standards of conduct that are required of members, and provides guidelines to assist members in avoiding allegations of sexual impropriety.

The College's Patient Relations Program

The *RHPA* requires every regulated health profession's college to have a Patient Relations Program that includes measures for preventing and dealing with sexual abuse of patients. The measures must include educational requirements, guidelines for the conduct of members with their patients, training for College staff and provision of information to the public. The primary responsibility for the Patient Relations Program lies with the College's Patient Relations Committee.

Definition of sexual abuse

Sexual abuse is defined in the Code as:

- a) sexual intercourse or other forms of physical sexual relations between the member and the patient;
- b) touching, of a sexual nature, of the patient by the member; or
- c) behaviour or remarks of a sexual nature by the member towards the patient.

According to the Code, touching, behaviour or remarks of a clinical nature appropriate to the services provided are not considered to be touching of a 'sexual nature'.

Discipline and Penalties

If a member is found to have committed an act of professional misconduct by sexually abusing a patient,

sanctions imposed by a panel of the Discipline Committee may include any or all of the following:

- revoking the member's certificate of registration;
- suspending the member's certificate of registration for a specified period of time;
- imposing specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time;
- reprimanding the member;
- requiring the member to pay a fine of up to \$35,000 ;
- requiring the member to reimburse the College for the cost of therapy; and counseling provided for the sexually abused patient under a program established by the College.

If the sexual abuse consisted of or included:

- sexual intercourse;
- genital to genital, genital to anal, oral to genital, or oral to anal contact;
- masturbation of the member by, or in the presence of, the patient;
- masturbation of the patient by the member;
- encouragement of the patient by the member to masturbate in the presence of the member

a panel of the Discipline Committee is required by the Code to:

- **revoke, for a minimum of five years**, the member's certificate of registration; and
- **reprimand the member.**

In addition, the optometrist may be fined up to \$35,000 and be required to reimburse the College for the cost of therapy and counseling provided for the sexually abused patient under a program established by the College.

Prevention

Members need to be exceptionally careful in their interaction with patients to ensure that their behaviour is not misinterpreted. Suggestive comments, profanity or sexual jokes may be misunderstood and could lead to allegations of professional misconduct. Optometrists should be aware of how their behaviour may be perceived by the patient as well as anyone who may observe or overhear the interaction.

Members should also be aware that patient expectations differ based on cultural background, religion, gender, age, and sexual orientation. Accordingly, a high level of respect and sensitivity is required to ensure that people of all backgrounds are treated with dignity.

The College advises all members to take a second look at their behaviour, be alert to the potential for allegations of sexual impropriety and, where necessary, change their behaviour.

The following advice is provided to assist members in avoiding allegations of sexual impropriety or sexual abuse:

- Having a patient disrobe is never appropriate.
- Hugging and kissing is inappropriate and should never be initiated by the optometrist.
- Touching should only be used as necessary to facilitate the optometric examination. Physical assistance may be required to facilitate patient positioning and head, eyelid or brow manipulation for ocular examination.
- Reclined patient positioning for examination may make a patient feel vulnerable. The reason for reclining the patient should be explained, and consent obtained.
- Comforting or reassuring a nervous or upset patient should be done with words rather than with touch.
- Appropriate touching for greeting purposes (such as shaking hands) or for assisting in the transfer of patients (for example from a wheel chair to examination chair), may enhance the comfort of a patient.
- Face to face proximity as is required in direct ophthalmoscopy should be explained. Patient and doctor comfort may be enhanced through the use of a face mask.
- Questioning and conversation must avoid references to sexual practices, thoughts, and orientation except where necessary, as in cases of diagnosis and treatment of ocular manifestations of sexually transmitted disease.
- Do not comment on a patient's appearance, clothing, or body unless clinically necessary.
- Do not tell jokes or stories of a sexual nature.
- Do not display material within the office that is sexual or suggestive, or may be offensive to patients or staff.
- Ensure that a member of the office staff or a third party is in attendance when services are performed within the optometry office outside of normal office hours.

If a patient initiates sexually inappropriate conversation or behaviour, this should be respectfully discouraged and a record of the incident made. Having a staff member or third party in attendance throughout the examination may help prevent misunderstanding or accusation. If the patient persists in the inappropriate behaviour, the optometrist should end the optometrist/patient relationship by dismissing the patient.

Because of the power differential in the optometrist/patient relationship, it is always the responsibility of the

optometrist to maintain appropriate boundaries. Sexual activity between an optometrist and a patient, even if perceived as consensual by those involved, is by definition considered to be professional misconduct.

Dating patients

Because of the broad definition of sexual abuse in the *RHPA*, it is problematic for an optometrist to have a social relationship with a current patient. There are different types of social engagements that may be considered “dating”, however professional misconduct occurs whenever a relationship with a patient involves behaviour or remarks of a sexual nature.

There are ethical dilemmas beyond the potential for sexual abuse allegations that may arise when dating a patient. The best course of conduct for members is to avoid dating any current patient. If an optometrist intends to date a patient, he or she should first terminate the patient/practitioner relationship by dismissing the patient.

The *RHPA* does not provide exemption from the sexual abuse provisions for a spouse who is also a patient, however recent interpretations of this regulation imply that the sexual abuse provisions were not intended to prevent members from treating their spouse¹.

Sexual harassment of office staff

While not dealt with in the *RHPA*, any form of harassment (sexual or otherwise) of office staff, including professional associates, may lead to allegations of professional misconduct.

A staff member who has received assessment or treatment services from an optometrist is considered to be a patient for the purpose of applying the sexual abuse provisions of the *RHPA*.

Mandatory Reports

If, in the course of practising the profession, an optometrist obtains reasonable grounds for believing that another regulated health professional has sexually abused a patient, the optometrist must make a report to the Registrar of the College of which the alleged abuser is a member. The report must be made within 30 days of obtaining such information and must contain the name of the reporter, the name of the alleged abuser, the details of the alleged abuse, and the name of the patient (but only if the patient consents in writing to the inclusion of his or her name in the report).

¹ Stienecke, Richard, *A Complete Guide to the RHPA*, page 10-4.1, Canada Law Book Inc., Release No. 6, November 2000

In response to a number of questions being dealt with by the office of the Information and Privacy Commissioner, the Commissioner asked that the following information be passed on to the College's members.

Privacy Matters:

Here's what health professionals are asking about Ontario's new health privacy legislation

By Ann Cavoukian, Ph.D.
Information and Privacy Commissioner/Ontario

Since the *Personal Health Information Protection Act (PHIPA)*, came into effect on November 1, 2004, my office has received more than 3,000 calls and e-mails from professionals in the health sector with questions regarding the implications and implementation of *PHIPA*.

One of the most common questions over the past few months has been: "**Why is PHIPA necessary when we already have the federal Personal Information Protection and Electronic Documents Act (PIPEDA)?**"

While the federal *Act* was designed to regulate the collection, use and disclosure of personal information within the commercial sector, *PHIPA* establishes a comprehensive set of rules about the manner in which personal health information may be collected, used, or disclosed across Ontario's health care system. *PIPEDA* was never designed to address the intricacies of personal health information.

In the near future, I anticipate seeing a final exemption order recognizing the substantial similarity of Ontario's *PHIPA* to the federal *PIPEDA*, so that health information custodians covered by *PHIPA* will **not** also be subject to *PIPEDA*.

We have received queries that cover a wide range of scenarios under *PHIPA* – issues that range from the extent of patient information being shared between health information custodians to whether a parent can obtain information about what prescriptions his daughter is obtaining from a pharmacy. Here is a short sampling of the questions we have received since *PHIPA* came into effect.

One caller was a physiotherapist who works at a health club and who shares patient information with non-regulated health professionals. He wanted to know if

staff, such as personal trainers and fitness instructors, would be considered health information custodians and if he would need to get written consent from patients to share their information with such staff members.

Our response was that, generally, the non-medical staff of a health club would not be considered to be *health information custodians*. The *Act* requires that consent to the disclosure of personal information by a *health information custodian* to a *non-custodian* must be express, and not implied. The physiotherapist would need express consent to pass on personal health information to staff such as personal trainers and fitness instructors. (As well, a *non-custodian* who receives personal health information from a *custodian* may, in general, only use that information for the purpose for which the *custodian* was authorized to disclose the information.) Obtaining consent at the beginning of the process would enable the physiotherapist to share information as needed, with his co-workers.

The manager of a long-term health care facility wrote us to ask if physicians who have admission privileges and are contracted for medical services – but who are not staff – should be asked to sign confidentiality agreements the same as staff, volunteers and other agents.

While *PHIPA* does not contain any provisions that relate specifically to a requirement to sign confidentiality agreements, it does state that *health information custodians* are required to take steps that are reasonable to protect the personal health information in their custody. Additionally, *PHIPA* also states that a *custodian* is required to handle records in a secure manner, so having confidentiality agreements in place is just one of the steps that *custodians* could take to help protect the information in their custody.

In this specific instance, the physicians that are contracted to provide services in the facility would likely be considered agents of the facility. Under *PHIPA*, the *custodian's* contact person is required to ensure that all agents of the *custodian* are appropriately informed of their duties under the law, which may include the signing of confidentiality forms.

One of the more challenging questions was from a pharmacist who wanted to know what his responsibilities were in a case where the cardholder of a prescription drug plan wanted to know the details of drug usage by a family member covered under the drug plan. Would the family member need to give permission or sign a consent form?

This would be a case of disclosure of personal health information by a *health information custodian* to a *non-health information custodian* which, generally, can only be done on the basis of express consent. Accordingly, a best practice would be to seek consent from the other family member or members who are covered under the cardholder's health plan. This is definitely the case if the information to be disclosed is that of an adult, such as a spouse, or children 16 or older. In the case of children under 16, information may be released without consent to the custodial parent, with *certain exceptions*. For example if the child is capable and disagrees, then the child's decision prevails.

If you, or your office, have a question regarding the *Personal Health Information Protection Act, 2004*, please do not hesitate to contact us at info@ipc.on.ca. You can also find many useful publications about *PHIPA* on our website, www.ipc.on.ca.

The following article appeared in the December 2004 issue of the Canadian Medical Protective Association (CMPA) Information Letter and is reproduced here with permission.

Shared Care between Ophthalmologists and Optometrists

By Dr. Anne Cornet, Medical Officer

A member who is an ophthalmologist called the CMPA asking for advice on the medico-legal risks of sharing a patient's care with an optometrist. The member explained that, due to a shortage of ophthalmologists in the area, many of these specialists are referring their glaucoma or post-cataract surgery patients to an optometrist for follow-up care. In these cases, the ophthalmologist continues to see the patient, but infrequently.

Here's how the CMPA responded:

The CMPA pointed out that the courts often emphasize a physician's duty to provide or arrange adequate follow-up care for patients, and it is therefore important for

ophthalmologists to see that their patients receive the appropriate follow-up care.

It is the ophthalmologist's duty to decide if the follow-up care can be adequately provided by an optometrist or if an ophthalmologist must provide the care. As each physician or independent health care professional is responsible for his or her own actions, the ophthalmologist will not usually be held responsible for the care provided by an optometrist. However, the ophthalmologist may be held responsible if the patient's care was inappropriately referred to a health care professional not qualified, not entitled or not capable of providing the required care.

Both the ophthalmologist and the optometrist should discuss, understand and accept their respective roles and responsibilities in this collaborative relationship. It is also important for the ophthalmologist to give precise and clear instructions to the patient regarding the need for follow-up. The clearer the instructions given to the patient and optometrist, the easier it will be for the ophthalmologist to convince a judge that proper instructions for follow-up were given.

In some jurisdictions, ophthalmologists are more likely to share care with family physicians or other health care professionals, and the same principles apply.

As always, the standard of care expected of physicians is that of a normal, prudent practitioner of the same experience in similar circumstances. Members would be wise to keep in mind that guidelines or standards established by provincial licensing authorities or medical specialty organizations will often influence a court's determination of the appropriate standard of care. It is not the CMPA's role to comment on standards of care or areas of competence, nor to define the scope of practice. Ophthalmologists might wish to contact their medical specialty organization as well as any relevant professional association of optometrists to obtain information about an optometrist's scope of practice, training and qualifications and delegation to optometrists.

If you have specific questions on shared care in your own practice, you are encouraged to call the CMPA for more information.

Published up to four times a year, the CMPA Information Letter offers CMPA members articles and cases to illustrate lessons learned in particular areas of medico-legal risk.

Launch of Public Education Campaign

College supports Federation communications

The Federation of Health Regulatory Colleges started airing a new radio ad campaign on April 18, 2005 to raise consumer awareness about regulated health professions and the role of health colleges. As a member of the Federation, the College has helped to fund this initiative.

It's not a game...your health matters, is the first in a series of ads to help consumers understand the value of regulated health professions and what regulation means to them. The ads will run on many major radio stations throughout the province from April 18 to May 15 and again from May 30 to June 26, 2005.

The goal of the ads is to make the audience aware of the public mandate of the Ontario regulatory colleges and to raise awareness about the standards required to be a regulated health professional in Ontario.

The campaign itself features a game show where contestants try to answer questions about which health professions are regulated and what health colleges do. The lively, fun format of the ads is designed to engage listeners, prompt them to ask meaningful questions and provide them with a resource for further information.

In addition to the ads, a new website has been developed to provide a key link to further information about each of the regulated professions in Ontario. The website address is www.itsnotagame.ca.

In order to gauge the success of the initiative, public polling was conducted prior to the start of the campaign to establish a baseline of public knowledge and awareness that will continue to be measured at key times throughout the campaign.

The Federation's public communication initiative will be a multi-year program. Once the initial goal to raise awareness about regulated health professionals and health colleges has

been accomplished, the Federation will develop new campaigns about standards and quality, ensuring competence, public protection and accountability.

This is the first joint ad campaign undertaken by the Federation. The Federation includes the 21 colleges that regulate 23 health professions in Ontario.

Stratified Random Sampling

Policy Update

On April 15, 2005, Council approved an update to the College's policy for Stratified Random Sampling for the Quality Assurance program.

Stratified Random Sampling was adopted when it was shown that there is a direct correlation between the number of years in practice and the likelihood of a member having deficiencies in practice. Council agreed that the Practice Assessment component would be made more efficient if a greater percentage of members who have been practising longer were selected.

The College has an agreement with the Canadian Optometric Regulatory Authorities (CORA) to randomly assess 5% of the membership each year. Due to a calculation error, the policy approved last September did not result in 5% of members being assessed each year. To remedy this, the policy was updated so that the Quality Assurance Committee will select a sample according to the following:

Stratum	Years in Practice	% of Group Selected
1	3 - 14	5%
2	15 - 24	7%
3	25 or more	10%

Each year, members who meet one of the following criteria are exempt from random selection:

- have been registered with the College for less than 3 years;
- have been discharged from a Practice Assessment within the previous five years;
- have successfully challenged the CSAO within the previous three years; or

- are holding a full-time faculty position at the University of Waterloo School of Optometry

The following article originally appeared in the February 1, 2005 edition of the Medical Post and is reproduced here with permission. While dealing specifically with physicians, the concepts are also relevant to optometric practice.

Respect a major factor in avoiding malpractice suits

How you communicate affects patients' willingness to sue

By Bill Rogers

Believe it or not, getting sued for malpractice seems to have very little to do with whether you actually commit malpractice. This nugget of counter-intuitive gold comes from a new book, *Blink*, by Malcolm Gladwell, staff writer for *The New Yorker* magazine.

Apparently it's all a question of tone. Treat your patient with respect, and you probably won't get sued even if you make a mistake. But if you're gruff, fail to take time to listen and "talk down" to a patient, you'd better watch out.

In *Blink*, Gladwell delves into the mystery of the snap decision, the choices we make in the blink of an eye. The subtitle of the book is "The Power of Thinking Without Thinking," and it turns out snap decisions aren't as simple as they seem. Often they are the best decisions we make.

In the course of the book's fascinating journey, Gladwell talks about something called "thin slicing," whereby humans can make startlingly accurate assessments based on nothing but a mere glimpse. For instance, Morse code experts in the Second World War could tell precisely which enemy commander was tapping out a message—regardless of what the message said—based on each commander's telltale style of tapping.

Gladwell applies thin slicing to medical malpractice. He asks you to imagine you've been given the task of predicting who, among a group of doctors, is most likely to be sued. You might think the best way to proceed would be to take a look

at each doctor's training, credentials and whether they've made mistakes in the past few years. But no. You'd be better off just listening to brief snippets of conversation between each physician and his or her patients. Just as a bird watcher can spot a wild turkey at 200 yards, you can spot a doctor at risk of being sued just by hearing a thin conversational slice. The key is to listen for respect, or lack thereof.

Medical malpractice lawsuits have been studied and analysed, notes Gladwell, and it has been shown that there are highly skilled doctors who are plagued by lawsuits, and at the same time there are doctors who make a large number of mistakes and yet never have a legal claim filed against them. And of all the patients who are injured by a physician's negligence, an overwhelming number never sue. This, says Gladwell, means patients don't sue doctors because they have been injured by faulty medical care; they sue because they feel the doctor has treated them badly, on a personal level.

How can you steer clear of this pitfall? It seems quite straightforward. Gladwell cites medical researcher Wendy Levinson, who has recorded hundreds of doctor-patient conversations. She discovered that the doctors who had never been sued spent an average of about three minutes longer with each patient. They tended to make "orienting" comments, such as "First, I'll examine you, then we'll talk the problem over," or "I will leave time for your questions." They tended to listen actively, saying things like, "Go on, tell me more about that." They were more likely to laugh and be funny during the patient visit.

Gladwell cites astounding research done by psychologist Nalini Ambady suggesting you can predict whether a doctor will get sued solely based on the tone, pitch and rhythm of the voices in a doctor-patient conversation. Ambady took Levinson's tapes of doctor-patient conversations and "content filtered" them, eliminating all the high-frequencies. This meant that individual words couldn't be recognized—all you could hear was a kind of garble.

Then a panel of judges listened to little snippets, or thin slices, of this garble and rated it for qualities such as warmth, hostility, dominance and anxiousness. These judges knew nothing about the doctors' skills, training, practice specialties—they didn't even know what the doctors were saying. They were merely listening for tone of voice. Using only this information, it was possible to tell which doctors got sued and which ones didn't.

The key was that if a doctor's voice was judged to sound dominant, the doctor tended to be in the sued group. Voices that were judged to sound less dominant and more concerned tended to be in the non-sued group.

"Could there be a thinner slice?" asks Gladwell. Malpractice sounds like an infinitely complicated, multidimensional problem. But in the end, he says, it comes down to a simple matter of respect. And the most fundamental way that respect is communicated is through tone of voice.

Gladwell cites leading U.S. medical malpractice lawyer Alice Burkin, who says "people just don't sue doctors they like." On the other hand, if they develop a dislike for a doctor, they'll sue that doctor, even if the medical mistake was someone else's fault! One of her clients wanted to sue a certain specialist, but was told it wasn't the specialist who was negligent, it was the primary care physician. The client didn't care what the primary physician had done—because she loved her, and wasn't willing to sue her.

"Next time you see a doctor," Gladwell writes, "and you sit down in his office and he starts to talk, if you have a sense that he isn't listening to you, that he's talking down to you, and that he isn't treating you with respect, listen to that feeling. You have thin-sliced him and found him wanting."

Bill Rogers (LLB) is a law journalist who covers medical and pharmaceutical legal matters. Readers with legal news can contact him care of the Medical Post or at rogersmedlaw101@sympatico.ca.

Annual Meeting

Election results announced

More than 150 members were in attendance at the College's Annual Meeting held in Hamilton on March 30, 2005.

The meeting was led by Dr. David White, President, Dr. Mark Teeple, Vice President and Dr. Murray Turnour, Registrar, who updated members on a variety of activities undertaken over the past year, as well as issues currently being pursued by the College.

As the first item of business, Dr. White announced the 2005 Council Election results as follows:

Dr. Linda Bathe, Provincial District

Dr. Michèle Martin, Eastern District (acclaimed)

Dr. Lorne Berman, Central (GTA) District

Dr. Paul Monk, Northern District (acclaimed)

Responding to members' questions

The meeting continued as the floor was opened up to questions. Many of the questions focused on how to interpret the OHIP Schedule of Benefits for Optometry Services that came into effect on November 1, 2004. The question and answer session provided valuable feedback to the College and identified issues of interest and concern to members. For those who were unable to attend the meeting, some of the member questions and College responses are detailed below.

Q: How do I explain to my patients the existence of what seems to be a two-tiered payment system, i.e., one dollar value placed on exams covered by OHIP and a higher dollar value placed on exams not covered by OHIP?

A: The College understands the difficulty members have in explaining this to their patients. The Ontario Association of Optometrists (OAO) is working hard to ensure that OHIP pays optometrists fairly for their work. The College supports the OAO in bringing this price differential to the attention of the Ministry of Health and Long-Term Care.

Q: How should an optometrist manage a patient between the ages of 20 and 64 who is at risk for glaucoma but who cannot afford the cost of regular eye exams?

A: The optometrist's obligation has been met when the risk factors and the need for regular check-ups have been clearly communicated to the patient. It is up to the individual optometrist to decide if he or she wishes to provide services pro bono.

Q: Can the College assist optometrists in identifying service clubs that may assist individuals who cannot afford regular eye exams?

A: The charitable focus of individual service clubs varies from one community to the next. Compiling this information and keeping it up to date would require considerable resources and does not fall within the College's mandate.

Q: Isn't the current OHIP schedule an example of age discrimination?

A: This is an interesting interpretation of the current OHIP schedule that members may wish to bring to the attention of the OAO as they lobby for change.

Q: Why is the OMA successful in their negotiations with the Ministry when optometrists get pushed to the side year after year?

A: The College understands members' frustration with the OHIP fee schedule negotiation process, however it is up to the OAO to manage this particular issue.

Q: Has there been any change to the prohibition on optometrists hiring opticians?

A: At their meeting in January 2005, Council passed a draft Conflict of Interest (COI) Regulation that would amend the current regulation to allow freedom of association. The consultation process for this regulation will include a Conflict of Interest Roadshow to discuss the implications of the proposed regulation and gain feedback from members across Ontario. All members are urged to review the draft COI Regulation when it is distributed to them and to actively participate in the consultation process.

Q: What's the timeline for getting authorization to use TPAs?

A: The issue of authorizing TPAs to optometry was recently referred to HPRAC for review. There is no way to know if or when this authorization will be granted. However, in anticipation of a positive result, the College is developing a policy regarding training requirements for members who wish to use TPAs in their practice.

Thanking an extraordinary volunteer

Before the meeting was called to a close, Dr. White asked those present to join him in thanking a valued volunteer, Dr. Bruce Hawkins, for providing 20 years of continuous service to the College as a Council and committee member. Dr. Hawkins was first elected to Council in 1975 and served nine years, three of them as President. After leaving Council, he continued to work as a member of various committees and was elected to Council again in 1999. Though he chose not to run for a third term on Council this year, Dr. Hawkins continues to be involved with the College as a member of the Discipline Committee.



At the College's Annual Meeting on March 30, 2005, Dr. Bruce Hawkins (centre) was thanked for his many years of service to the College by Dr. Murray Turnour, Registrar (left) and Dr. David White, President (right).

Reporting CE Hours

Data error caught and corrected

Each November, members receive an Annual Report from the College. In addition to gathering and updating member information, the Report informs the member of how many hours of continuing education (CE) he or she has earned during the current CE cycle and/or carried forward from the previous cycle. This year, a computer error resulted in inaccurate CE information being reported to some of our members.

The error has been corrected and the College has sent out letters to members with accurate CE information up to the end of 2004. **Only those members affected have been sent a letter.** If the CE information on the Annual Report sent to you at the end of 2004 was accurate, you will not receive a letter from the College about this matter.

Members are reminded that they are required to obtain a minimum of sixty (60) credit hours of continuing education during every three-year cycle. All credit hours must be related to the maintenance of the member's standards of practice or competence.

The current cycle runs from **January 1, 2003 to December 31, 2005**. Members who obtain more than the required number of hours may carry forward a maximum of twenty (20) hours to the next cycle.

COLLEGE OF OPTOMETRISTS OF ONTARIO COUNCIL & COMMITTEE MEMBERS (2005-2006)

MEMBERS OF COUNCIL/MEMBRE DU CONSEIL

Central Electoral District/ district électoral du centre

Dr. Lorne Berman
Dr. Deborah Lowy

Eastern Electoral District/ district électoral de l'est

Dr. Michèle Martin

Northern Electoral District/ district électoral du nord

Dr. Paul Monk

Western Electoral District/ district électoral de l'ouest

Dr. Mark Teeple

Provincial Electoral District/ district électoral provincial

Dr. Linda Bathe
Dr. Mike Cobean
Dr. Jim Wilkinson
Dr. David White

University of Waterloo/ Université de Waterloo

Dr. William Bobier

Lieutenant Governor in Council/ le lieutenant-gouverneur en conseil

Mr./M. Craig Bridges
Mr./M. Graham Coveny
Mr./M. Henry Hodowany
Mr./M. Charles Korman
Ms./Mme. Mary J. Lenihan
Mr./M. James Lexovsky
Ms./Mme. Nathalie Pardy

COMMITTEES/COMITÉS

Executive/le bureau

Dr. Mark Teeple, President
Dr. Linda Bathe, Vice President
Dr. Paul Monk
Mr./M. Graham Coveny
Ms./Mme. Nathalie Pardy

Clinical Practice/de l'exercice clinique

Dr. Paul Monk, Chair
Dr. Heather Blain
Dr. Ken Hadley
Mr./M. Charles Korman
Dr. Harvey Mayers
Dr. Paul Padfield
Dr. David White

Complaints/des plaintes

Dr. Deborah Lowy, Chair
Dr. Linda Chan
Mr./M. Henry Hodowany
Ms./Mme. Mary J. Lenihan
Dr. Jim Wilkinson

Discipline/de discipline

Dr. Mike Cobean, Chair
Dr. Lorne Berman
Mr./M. Craig Bridges
Mr./M. Graham Coveny
Dr. Bruce Hawkins
Dr. Jim Hoover
Mr./M. Charles Korman
Ms./Mme. Nathalie Pardy
Dr. Karin Simon

Ethics/de déontologie

Dr. Linda Bathe, Chair
Dr. Lorne Berman
Dr. Kan Chhatwal
Dr. Paul Chris
Mr./M. Graham Coveny
Dr. Agnieszka Cudowska

Fitness to Practise/d'aptitude professionnelle

Mr./M. James Lexovsky, Chair
Dr. Lorne Berman
Dr. Karin Simon

Optometry Review/d'étude de l'optométrie

Dr. Josée Martineau, Chair
Mr./M. G. William Atkinson
Dr. Dagmar Lutzi
Mr./M. Wayne Senis
Dr. Greg Simpson

Patient Relations/de relations avec les patients

Dr. Jim Wilkinson, Chair
Mr./M. Craig Bridges
Ms./Mme. Mary J. Lenihan
Dr. Josephine Pepe
Dr. Ken Robertson
Dr. Peter Shaw

Quality Assurance/d'assurance de la qualité

Dr. David White, Chair
Dr. Linda Bathe
Mr./M. James Lexovsky
Dr. Kamy Morcos
Dr. Patrick Quaid
Dr. Richard Samuel
Dr. Karin Schellenberg

Registration/d'inscription

Dr. Michèle Martin, Chair
Dr. Mike Cobean
Ms./Mme. Nathalie Pardy
Dr. Wendy Tam-Wai
Dr. Donna Williams-Lyn

Excellence in Optometric Care

Serving the Public Interest by Guiding the Profession



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