



## Draft Restrictive Drug Regulation and Standard Circulated

### College members and stakeholders asked to comment

On January 13, 2005, Council approved a draft restrictive drug regulation and an accompanying standards document, the *Standard of Practice of the Profession of Optometry for the Use of Drugs*, for circulation to College members and other stakeholders for comment.

Once feedback from stakeholders has been received and incorporated (as appropriate), the College proposes to submit the Regulation and Standard to the Ministry of Health and Long-Term Care to fill a gap in existing legislation. Under the *Regulated Health Professions Act (RHPA)* and the *Optometry Act, 1991*, the regulation of the use of drugs in optometry is such that a 'restrictive' regulation is required, meaning that unless legislation is developed specifically prohibiting the use of a drug, such use is permitted.

In May 2004, members received a *Guideline on the Use of Drugs by Optometrists* to inform them of the appropriate use of diagnostic and therapeutic pharmaceutical agents in their practice. This document was the basis for the *Standard of Practice of the Profession of Optometry for the Use of Drugs*.

All proposed regulation changes are circulated for a minimum of 60 days to College members for feedback

The RHPA requires all proposed regulation changes to be circulated for a minimum of 60 days to College members for feedback. Included as an insert to this issue of the *Bulletin* you will find a memo from Dr. Murray Turnour with the draft wording for a new restrictive drug regulation, the standards

document referenced in the regulation, and a feedback form that you may fill out and return to the College by regular mail, fax or e-mail.

You are asked to submit your comments by the end of the day Monday, May 2, 2005 for consideration. If you have any questions about the documents or the process by which they are submitted to the Ministry for approval, please contact Valerie Browne, Director, Office and Membership Services at [director@collegeoptom.on.ca](mailto:director@collegeoptom.on.ca).

### Upcoming Events

#### Council Election

Ballot Box Closes

March 23, 2005 (4:00 p.m.)

Election Day - March 24, 2005

#### Annual Meeting

March 31, 2005 - Hamilton, ON

#### Continuing Education Session

April 1, 2005 - Hamilton, ON

#### Council Meeting

April 14-15, 2005 - Toronto, ON

#### Jurisprudence Seminar and Examination

May 12-13, 2005 - Waterloo, ON

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# A Word from the President

## Change is not only possible, it's taking place

Did you feel that? I think the earth may have moved – just a bit. In the past I have expressed my frustration and dissatisfaction at the slow rate of positive change and the fast rate of negative change that the regulatory side of our profession seems to undergo. I am pleased to report to you that on January 13 a small but significant event occurred.



David J. White, O.D., President

After much hard work and many decibels of debate, the Ethics Committee of the College brought forward to Council a proposal for regulatory change. This proposal involves a change in our Conflict of Interest Regulation that controls, among other things, the nature of the working relationship between optometrists and other regulated health professionals. These proposals were accepted by Council and will be circulated to the membership for comment.

The Ethics Committee has asked some difficult questions: Is the public unnecessarily protected by a prohibition that prevents optometrists from hiring opticians? Is there a better way to manage a conflict of interest than to erect a wall between an optometrist's office and an optician's store? What is the potential for conflicts of interest when an optometrist is employed by another optometrist? By an optician? By a corporation?

These questions are only the beginning. Over the next weeks and months, the Ethics Committee will be bringing forward more proposals to change some of our Professional Misconduct Regulations, including the regulation dealing with "setting out the commercial laboratory cost incurred by the member in the provision of services". Is the public adequately or overly protected

by the concept of dispensing fees? If dispensing fees are necessary to provide protection, how should the College define 'commercial laboratory cost'? If these questions can be answered to the satisfaction of Council, more proposed regulations will be accepted and will be circulated to the membership for comment.

'Circulation for comment' – that sounds pretty benign. If the Council of the College were proposing a small housekeeping change in the regulations, it would be benign. With the significant changes that will be proposed, the circulation process will be far from benign. **WE WANT TO INVOLVE YOU.** To do that, the College will be launching a Road Show that will be bringing the proposed regulatory changes to a meeting place near you in the Fall of 2005! It is critically important that all members understand the proposed wording, and what those changes mean to the public and to our practices. I would like to encourage you to attend, learn, understand and participate. Details of these events will be provided in future *Bulletin* issues.

It is important to remember that at this time these proposed changes to the regulations are still just that – proposed. In order to govern the profession, these proposals must survive the consultation process, redrafting by College committees and final approval by Council. Subsequent to this, they must wind their way through the legislative process at Queen's Park to finally become law. The recent decision by Council to gather input from stakeholders is just one small step in a long process.

I would like to thank Dr. Linda Bathe and the members of the Ethics Committee who were charged with the monumental task of getting this ball rolling. Regulatory change is truly like affecting the path of a huge ocean-going freighter; small careful adjustments to the wheel will eventually overcome the forward momentum and keep us on a true course and out of the path of hazard and failure.

David J. White, O.D.

# Registrar's Report

## OHIP and Automated Visual Fields

On November 1, 2004 a new schedule of benefits for optometry services came into force. Since that time, the College has been working to understand what services the Ministry of Health and Long-Term Care intended to be insured or uninsured. One significant issue that requires clarification is what types of visual field assessments are insured, and under what circumstances.



Murray J. Turnour, O.D., Registrar

The lack of clarity around the insurability of visual field assessments has resulted in a significant number of telephone calls and e-mails to the College from members and the public.

“...the standards of practice of the profession did not change on November 1<sup>st</sup>.”

In all cases, the College responds that the standards of practice of the profession did not change on

November 1<sup>st</sup>. Members must do what is in the best interest of each patient and advocate on behalf of the patient.

The standards of practice do not require members to have every piece of optometric equipment available in their practice, and the Guide to the Practice of Optometry is quite clear as to the College's expectations of members when equipment is not available:

*When a practice does not have a specific instrument (e.g. perimeter), it is expected that members will have arrangements whereby the tests may be performed elsewhere and the results obtained for analysis and retention in the clinical record.*

When the standards of practice are applied to the provision of visual field assessments, it is clear that patients requiring such assessments must receive them in a timely manner. All optometrists are expected to be

able to provide a screening (confrontation) field. If a more complete assessment of peripheral vision is clinically necessary, the optometrist has the choice of referring the patient to another practitioner or service provider to have the field assessment performed, or of providing the assessment him/herself.

In mid-December, the Ontario Association of Optometrists requested that its members stop performing automated visual fields (AVF) and refer all patients requiring this assessment to ophthalmologists or public hospitals, whether or not the patient was insured under OHIP. When referring a patient elsewhere for the assessment, the optometrist may have to advocate on the patient's behalf for a timely referral.

It is up to individual members who have perimeters to determine for themselves if they wish to use the equipment and perform AVF. The College agrees with the Association that the decision the optometrist makes must be consistently applied. That is, if visual fields are not provided to one patient or group of patients, then they cannot be provided to any patient or group.

Some members of the public have called the College asking for clarification as to why their optometrist is not performing AVF. This is especially confusing to patients who had appointments scheduled but were called and, with little or no explanation, were advised that these appointments would be re-scheduled at a later date.

The College recognizes the autonomy of members to make decisions concerning their practice. Members should be guided in those decisions by the standards of practice noted above, and explain their decisions to their patients.

The nature and extent of OHIP coverage for automated visual fields has yet to be finally determined. Members can expect further communication from the College as our understanding of the Ministry's intentions becomes clearer.

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

# New Policy on Delegation and Assignment

## Safeguards approved by Council

The provisions for delegation of controlled acts in the *Regulated Health Professions Act* (RHPA) and the Professional Misconduct Regulations under the *Optometry Act* allow optometrists to delegate the controlled acts authorized to optometry, as well as to receive delegation of controlled acts not directly authorized to optometry.

On January 13, 2005, Council approved a policy drafted by the Clinical Practice Committee that places appropriate safeguards on the giving and receiving of delegation by optometrists. The policy also provides guidelines for appropriate assignment of non-controlled procedures to optometric staff. The policy is reproduced in full here:

## Policy on Delegation and Assignment

### Principles:

The Vision Statement of the College of Optometrists of Ontario is “to provide excellence in optometric care.” Both delegation and assignment of optometric procedures in appropriate circumstances allow for more timely

Council has approved a policy that places appropriate safeguards on the giving and receiving of delegation by optometrists.

delivery of optometric care, making optimal use of time and personnel.

Optometrists have a fiduciary duty of care to their patients.

This fiduciary duty may be maintained while allowing an optometrist to **assign** the performance of a non-controlled act to another individual, or to **delegate** a controlled act authorized to the profession in the *Optometry Act*, or to receive delegation of a controlled act

not authorized to optometry. The responsibility for the delegation and assignment always remains with the optometrist.

### Scope:

This policy applies to all optometrists registered and practising in Ontario.

### Controlled Acts:

The *Regulated Health Professions Act* (RHPA) identifies 13 controlled acts that may only be performed by members of certain regulated health professions. Optometrists are authorized by the *Optometry Act* to perform 3 of the 13 controlled acts, as follows:

- i. communicating a diagnosis identifying, as the cause of a person’s symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease
- ii. applying a prescribed form of energy
- iii. prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

### Purpose:

The purpose of this policy is to:

- i. clarify the difference between delegation of controlled acts and assignment of non-controlled acts;
- ii. describe when and how an optometrist may delegate or assign an act within the scope of practice of optometry; and
- iii. describe when and how an optometrist may receive delegation of a controlled act from another regulated health practitioner.

This policy replaces the College’s ‘Optometric Assistants’ policy.

### Guidelines for Delegation and Assignment:

- i. Practitioner-Patient Relationship: In most cases, delegation will only occur after the optometrist has interviewed the patient, performed an assessment, made recommendations, obtained an informed consent to proceed, and instituted a course of therapy. In some cases, where there are tests specified by the optometrist (where a previous relationship had been established) delegation may take place in advance of seeing the practitioner. It is expected that the

practitioner will meet and assess the patient as soon after the procedure has been performed as practicable.

Assignment may often occur prior to the patient meeting the optometrist.

- ii. Delegation should only take place if the practitioner is present in the office. The optometrist is expected to ensure the individual receiving the delegation has the appropriate knowledge, skill and judgement to perform the delegated act.
- iii. The optometrist should establish a process for delegation and assignment, or ensure that there is one in place, that includes,
  - a. education, ensuring the currency of the delegate's knowledge and skills
  - b. ensuring that the delegate maintains competence in the performance of the delegated act
  - c. documentation for execution of procedures
  - d. ensuring the delegate has been delegated only those acts that form part of the optometrist's regular practice and daily competence
- iv. Delegation should occur with the informed consent of the patient where feasible. Informed consent may be explicit or implicit depending on the particular activity.
- v. The optometrist should ensure proper supervision of the delegation. The level of supervision will vary according to the risk of harm of the delegated act.
- vi. The optometrist is expected to ensure there is an ongoing quality assurance mechanism.
- vii. Examples of the types of non-controlled acts that may be assigned to optometric staff include:
  - a. Collecting preliminary case history information.
  - b. Conducting preliminary tests or procedures such as:
    - i. visual acuity
    - ii. colour vision
    - iii. stereoacuity
    - iv. visual skills
  - c. Operating automated instrumentation.

### Receiving Delegation of Controlled Acts:

In the public interest, there are situations when an optometrist should receive delegation from another

regulated health practitioner (RHP) to perform a controlled act not authorized to optometry. Medicine has regulations, established protocols and training for

**The responsibility for the delegation and assignment always remains with the optometrist.**

delegation that could apply to optometrists. In certain situations, optometrists have the knowledge, skill and judgment to

perform certain delegated controlled acts, particularly when these acts involve training and guidance from the delegator.

In order for an optometrist to receive delegation from another RHP, all of the following criteria should be met:

- i. a process for receiving delegation should be in place;
- ii. the member should have a reasonable belief that the RHP delegating the act, is authorized to perform the act, has the ability to perform the act competently, and is delegating in accordance with relevant regulations governing his or her profession;
- iii. the optometrist should be competent to perform the act safely, effectively, and ethically;
- iv. appropriate resources should be available and serviceable, such as equipment and supplies;
- v. the delegated act should be clearly defined;
- vi. the delegated act should be related to the scope of practice of optometry, i.e., the assessment of the eye and vision system and the diagnosis, treatment and prevention of disorders of refraction, prescribed diseases, and sensory and oculomotor disorders and dysfunctions of the eye and vision system; for example, being delegated to remove a corneal foreign body would be a possible act that could apply;
- vii. the duration of the delegation should be clearly defined and relate to a specific patient;
- viii. the optometrist should ensure that patient consent to having the act performed under delegation to the optometrist is obtained and recorded in the patient's health record;
- ix. a mechanism should exist to contact the RHP who delegated the act if there is an adverse outcome;
- x. the identity of the RHP delegating the controlled act and of the member performing the controlled act should be recorded in the patient health record.

# General Meeting of the College

Council has called a General Meeting of the membership to take place on Thursday, March 31, 2005 in Hamilton, Ontario. All members of the College are invited to attend a continental breakfast with the members of Council, followed by the meeting. The President and Registrar will provide an update of College activities throughout 2004, and members will have an opportunity to ask questions during an informal 'question and answer' period.

On Friday, April 1, the College is sponsoring a continuing education program as part of the Ontario Association of Optometrists' Annual Symposium in Hamilton. Mr. Roy Stephenson will be speaking about medical error and the biases that affect how medical errors are dealt with. Mr. Stephenson's talk is open to all members of the College. We hope you'll join us in Hamilton!

Hamilton Convention Centre  
1 Summers Lane, Hamilton, Ontario

## College of Optometrists of Ontario General Meeting

Thursday, March 31, 2005

8:00 – 8:45 a.m. Continental Breakfast  
8:45 – 10:00 a.m. General Meeting for Members

## Continuing Education Session

Friday, April 1, 2005

10:30 a.m. – 12:00 p.m. Mr. R. Stephenson: Medical Error

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# Personal Health Information Protection Act

## FAQs

The College frequently receives calls from members inquiring about their obligations under the *Personal Health Information Protection Act* (PHIPA), which came into effect

on November 1, 2004. The following information comes from the Information Privacy Commission (IPC) publication, *Frequently Asked Questions: Personal Health Information Protection Act*.

## When is implied consent sufficient?

In practice, a health information custodian is not required to obtain an individual's written or verbal consent every time personal health information is collected, used or disclosed.

*PHIPA* permits a custodian to assume implied consent where information is exchanged between custodians within the circle of care for the purpose of providing direct health care — unless a custodian is aware that an individual has expressly withheld or withdrawn his/ her consent. Consent may never be implied for an individual who specifies that his/her personal health information may not be collected, used or disclosed. Implied consent is also permitted if a health information custodian collects, uses or discloses names or addresses for the purposes of fundraising. In addition, if an individual has provided information about his/her religious affiliation to a health care facility, the facility may rely on implied consent to disclose the individual's name and location within the facility to a person representing his/her religious organization. Before making this disclosure, the facility must provide the individual with an opportunity to withhold or withdraw the consent.

The "circle of care" is not a defined term under *PHIPA*. It is a term of reference used to describe health information custodians and their authorized agents who are permitted to rely on an individual's implied consent when collecting, using, disclosing or handling personal health information for the purpose of providing direct health care.

## When is express consent required?

In certain circumstances express consent will always be required:

- Express consent is required for a disclosure of personal health information to an individual or organization that is not a health information custodian and is outside the circle of care.
- Express consent is required where information is disclosed by one custodian to another for a purpose other than providing or assisting in providing health care.

- Express consent is also required where a custodian:
  - Collects, uses or discloses personal health information other than an individual's name and mailing address for fundraising purposes;
  - Collects personal information for marketing research or activities; and
  - Collects, uses or discloses personal information for research purposes, unless certain conditions and restrictions are met.

## Access to Personal Health Information

With limited exceptions, *PHIPA* provides individuals with a general right to access their own personal health information held by a health information custodian and sets out a formal procedure for access requests.

An individual may request access to his/her own personal health information by submitting a written request to the health information custodian who has custody or control of the individual's health records. The request must contain sufficient detail to allow the custodian to locate the record in question.

The health information custodian should then provide either access to or a copy of the record. Otherwise, a written notice explaining why the record is not available must be provided to the individual seeking access.

A health information custodian must respond no later than 30 days after the request was made. Extensions beyond this 30-day time frame are allowed where meeting this time frame would interfere with the custodian's operations, or where outside consultations are required in order to comply with the request. In such situations, the custodian must inform the individual in writing about the delay and the reasons for the delay.

Health information custodians are responsible to assist individuals by providing access to their health records. Custodians may refuse access in limited situations only, where for example:

- the information in question is subject to a legal privilege;
- its disclosure could reasonably be expected to result in a risk of serious bodily harm to a person;
- the information was collected as part of an investigation; or
- another law prohibits the disclosure of that information.

*PHIPA* permits custodians to remove some of the

information to allow partial access to the individual. If a health information custodian denies an individual access to his/her personal health information, the individual has the right to file a complaint with the IPC.

Health information custodians may charge a reasonable fee for providing access to an individual's personal health records. *PHIPA* also permits a custodian to waive all or part of the fee associated with an access request. In charging a fee, *PHIPA* requires custodians to provide the individual with a fee estimate limited to the prescribed amount set out in the Regulations, if any, or an amount that is reasonable for cost recovery.

*For a complete copy of "Frequently Asked Questions: Personal Health Information Protection Act," please visit the IPC website at [www.ipc.on.ca](http://www.ipc.on.ca).*

## Practice Points

### When is a referral complete?

Referring a patient to another healthcare practitioner is something our members do regularly as part of their day-to-day practice. Managing a patient referral seems like a straightforward process, yet it is not always clear how much follow-up is required by the optometrist once the initial referral is made. At what point does responsibility for the referral transfer from the optometrist to the regulated health practitioner (RHP) receiving the referral? When is a referral 'complete'?

The College's Complaints Committee recently dealt with two complaints regarding referrals that were initiated in a timely manner but were not followed-up by the optometrist (or their office staff) to ensure the referral appointment was actually made. In each case, the optometrist relayed the request for referral by fax transmission to an ophthalmologist's office. The ophthalmologist's office did not, for whatever reason, receive or act on the faxed referral and consequently no appointment was made for the patient. The optometrist in each case told the Complaints Committee that the fax had been sent to the ophthalmologist's office but could not explain why it had not been received there or acted upon.

In each of these circumstances, the optometrist correctly identified a condition that required a referral and attempted

to make that referral in a timely manner. However, failure to follow up on the referral to ensure an appointment was made resulted in the patient making a complaint to the College. It is not clear if the clinical outcome in either case was affected by a delay in treatment.

Members are reminded that they are responsible for having office procedures in place that ensure that every referral results in an appointment being made with the RHP to whom the patient was referred. In some cases, the RHP's office will provide appointment information directly to the patient and in others the optometrist is asked to relay the information to the patient. In either case, the optometrist should keep track of the referral and follow up as necessary until an appointment has been made and the patient notified.

The Complaints Committee recognizes that in many parts of the province a faxed request for referral is required before an appointment can be made with an ophthalmologist or other RHP, and this should be taken into account when referral procedures are developed. As a final point, members should ensure that all referral appointments and confirmations are documented in the patient's health record.

## Other news in Brief

### Council adopts new Strategic Plan

"I'm pleased that Council has accepted our recommendation" is how Dr. Mark Teeple, Vice-President and Chair of the Strategic Planning Committee, responded when the Council of the College unanimously adopted a new Strategic Plan on January 13, 2005. Included in this Strategic Plan are priorities to deal with excellence in optometric care and governance.

For nearly a year the Strategic Planning Committee had been reviewing, consulting and drafting a strategic plan that will guide the College over the next three to five years. Their hard work culminated in a proposal that was quickly adopted. Dr. Teeple credits the swift passage to the wide consultation that his Committee undertook. This consultation included a facilitated discussion with members

of Council, College staff, Committee members and outside stakeholders.

A copy of the Strategic Plan is included as an insert to this issue of the *Bulletin*.

## New UWSO program to help International Graduates

The University of Waterloo School of Optometry (UWSO) recently announced that they have received funding of \$551,600 from the Ministry of Training, Colleges and Universities to develop a program to assist international optometric graduates who wish to practise in Ontario.

The College is proud to be one of a number of partners collaborating with UWSO on this important program, called "Looking forward: Toward Optometric Practice in Ontario." The program will take into consideration the candidates' existing academic and clinical experience, bridge identified gaps in that experience, and prepare them for the provincial registration system such that they may practise in Ontario without compromising the standard of optometric care in this province. The program will include profession-specific language training and communication skills, and participants will learn about the professional healthcare culture in Ontario and be provided with Canadian workplace experience.

## Vision Institute appoints new Executive Director

The Board of Directors of the Vision Institute of Canada (VIC) has informed the College of the appointment of Dr. Paul Chris of Toronto as the new Executive Director of the Institute, following the retirement in December 2004 of Dr. Mitchell Samek. Dr. Chris, who served as Treasurer of the VIC during 2004, has practised optometry in Toronto since graduating from the University of Waterloo in 1976. From 1994 to 2004, Dr. Chris served on the Council of the College of Optometrists of Ontario, including two years as President. Dr. Chris brings a renewed commitment to the success and growth of the Vision Institute, and to its charitable work on behalf of Canadian Optometry.

## Excellence in Optometric Care

Serving the Public Interest by Guiding the Profession



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