

Do you Treat your Spouse?

If you do, you should stop

In February 2010, the Ontario Court of Appeal released its decision in *Leering v. College of Chiropractors of Ontario*. This decision, which involves the 'zero tolerance' provisions relating to sexual abuse of patients in the Health Professions Procedural Code (Code) under the *Regulated Health Professions Act*, has significant and widespread implications.

To understand this case and how it affects the practice of optometry, members of the College need to be aware that the legislation defines sexual abuse of a patient by a member 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.

Note: Touching, behaviour or remarks of a clinical nature appropriate to the service provided do not constitute sexual abuse.

In addition, the legislation sets out mandatory orders (penalties) that a College's Discipline Committee must impose when a regulated health professional is found to have committed professional misconduct by sexually abusing a patient, as follows:

1. Reprimand the member.
2. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following,
 - i. sexual intercourse,
 - ii. genital to genital, genital to anal, oral to genital, or oral to anal contact,
 - iii. masturbation of the member by, or in the presence of, the patient,
 - iv. masturbation of the patient by the member,
 - v. encouragement of the patient by the member to masturbate in the presence of the member.

Which brings us to the *Leering* case. Dr. Leering, a chiropractor, met a woman and they commenced a relationship including a sexual relationship. They moved in together, and approximately four months later Dr. Leering began to give the woman regular chiropractic adjustments. A patient file was opened, treatments were given in the office and Dr. Leering referred to the woman as his "patient" in correspondence. After approximately six months, the couple separated.

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Upcoming Events

Council Meeting
June 18, 2010
Toronto, ON

**Ontario Optometric
Jurisprudence Exam**
September 7, 2010
Toronto, ON

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A Word from the President

Two updates: TPAs and unauthorized practice

There are two long-standing issues that have been of particular interest to members and merit regular updates. The first issue is the prescribing of therapeutic pharmaceutical agents (TPAs). It's now been three years since the *Optometry Act* was amended giving our profession the additional authorized act of "prescribing drugs designated in the Regulations" and I know that our members are all as anxious as I am to know when we can start to prescribe drugs. Before that can happen, we need to have the Designated Drugs Regulation passed. The College began working on what a Designated Drugs Regulation would contain and look like even before the new authorized act was given to the profession. Several iterations of a draft Designated Drugs Regulation have been submitted to the Ministry of Health and Long-Term Care, the most recent being in December 2009.



Richard Kniaziew, O.D.,
President

Based on the feedback we're getting about that December submission, the College and the Ministry are very close to agreement. At the Executive Committee meeting in May, we reviewed a re-draft of the Regulation prepared by the Ministry. Getting a draft BACK from the Ministry shows significant progress!

"The Ministry has made it very clear that the Designated Drugs Regulation must contain a list that names specific drugs, not classes or categories of drugs."

The Ministry has made it very clear that the Designated Drugs Regulation must contain a list that names specific drugs, not classes or categories of drugs. I know some members have expressed concerns about which drugs will – or will not – be included on the list. I'm pleased to say that topical glaucoma drugs and steroids remain in the Regulation. The decision to stick to our guns on these two categories was not an easy one to make. Taking them out might have meant speedier passage of the Regulation, but it would also mean having to get them back at a future date and there is no way of knowing how many years that might take. My personal opinion is that it was worth the extra time it has taken to ensure they are included now.

The College is working with the Ministry to facilitate passage of this Regulation. Your Registrar, Dr. Turnour, is in contact with the Ministry at least every other week (if not more frequently) to monitor progress.

The second issue that I'd like to address is what seems to be the perennial matter of Great Glasses and Mr. Bruce Bergez, found by the Courts to be dispensing eyewear without a valid prescription from an optometrist or a physician and subsequently ignoring the order to cease this activity and ignoring the fines imposed. The College has been involved with this issue since 2003. The detailed history, including the various court decisions, is available on the College website at www.collegeoptom.on.ca (News – Archives – Legal Update). Needless to say, this has all been going on for far too long.

On June 28-29, the College will be back in the Superior Court in Hamilton to hear further legal arguments. For the first time, the Ministry of the Attorney General has intervenor status and will join us and the College of Opticians of Ontario as we continue to pursue this matter.

The Attorney General will ask the Court to appoint a Receiver/Manager to take over the operations of Great Glasses and issue warrants of committal for Bruce Bergez and his wife. Once the Court Decision is available, we will post it on our website at www.collegeoptom.on.ca.

Richard Kniaziew, O.D.

Registrar's Report

Financial co-management of cataract surgery

On Saturday, February 27, 2010 I participated in a panel discussion at the Toronto Cataract Course sponsored by the University of Toronto. The topic of discussion for the panel was Financial Co-management of Cataract Surgery. Other panelists included Dr. Bill Ulakovic, representing the Ontario Association of Optometrists, and Dr. Ike Ahmed, a Toronto ophthalmologist. Below are the highlights from my presentation.



**Murray J. Turnour,
O.D., Registrar**

Optometrists have the knowledge, skill, judgement and equipment to properly co-manage cataract patients. Optometrists are well positioned to follow the development of cataract and its impact on the patient's quality of life, and to discuss with their patients the most appropriate time to make a referral for surgery. After surgery, optometrists monitor the healing process and determine if things are going as expected. There should be a clear understanding between the optometrist and the ophthalmologist as to when a referral back to the ophthalmologist is necessary, or when a telephone consultation is appropriate.

With respect to referrals for surgery, the College expects that optometrists will discuss the recommendation with the patient, including the availability of surgeons in the area, and make a specific referral taking into account the patient's needs and wants. Ideally, for cataract extraction, a written referral is made to the surgeon including pertinent clinical information. For medical and legal reasons, there needs to be appropriate documentation of the referral. This documentation should include the referral letter and a consultation letter back from the surgeon.

When dealing with financial co-management of cataract surgery, it's important to note that it is a conflict of interest – and therefore professional misconduct – for an optometrist to:

- share fees with any person who has referred a patient;
- receive fees from any person to whom the member has referred a patient; or
- engage in any form of fee sharing, rebates or other indirect remuneration.

Optometrists are permitted to practise in association, partnership or while employing or under the employment of another optometrist or a physician. This means that employment/associate agreements must be with an optometrist, a physician, an optometry professional corporation or a medicine professional corporation. No other employment/associate arrangement is permitted.

Some optometrists are salaried employees of ophthalmologists and provide pre- and post-surgical care in the ophthalmologist's office. In this circumstance, payment is made to the surgeon by OHIP, a private insurance company or the patient. The surgeon pays the optometrist's salary. This arrangement is allowed by the regulations and is quite acceptable. In other situations, optometrists work in the ophthalmologist's office as an associate, again providing pre- and post surgical care. Payment to associates is usually on a percentage of income generated basis. This is acceptable to the College as well, since the regulation allows for "practise in association".

A more common situation is when the optometrist and ophthalmologist are working in different offices and the optometrist refers the patient to the ophthalmologist. The preferred billing arrangement in this situation is for each professional to bill OHIP, a private insurer or the patient for the services that he or she provides. Concerns arise when one professional – usually the ophthalmologist – collects money for a global service and uses the referring optometrist to provide some of those services. Any payment to the optometrist in this circumstance must be justifiable based on the time and level of skill required for the optometrist to deliver the service. In this situation, there must be clear communication to the patient or the insurer regarding what the payment is for and how it is being divided in order to dispel any suggestion that the payment is being made for the referral. The amount of the payment will vary depending on the extent of services the optometrist provides to the patient.

The College expects that referrals will be based on clinical considerations only – not the financial interests of the parties involved in providing care.

Murray J. Turnour, O.D.

Dilated Fundus Examination

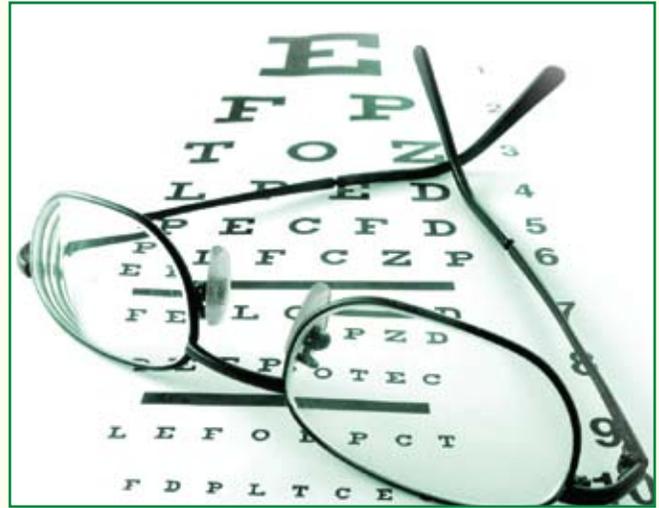
Imaging does NOT replace dilation

In the course of conducting random practice assessments, the Quality Assurance Committee is now routinely dealing with members who disregard their duty to perform a dilated fundus examination. These optometrists are relying, instead, on the information gained from a retinal image. This is an alarming trend.

In early 2008, the College published a policy on the use of Digital Imaging/Fundus Photography in Optometric Practice. Retinal imaging can be a useful tool for documenting retinal anomalies/pathologies and explaining them to patients by allowing them to “see what the doctor sees,” but it does not replace a dilated fundus exam. **Retinal imaging must be used in a way that is consistent with the established standards of practice of the profession. When there are clear indications for dilation, the use of retinal imaging without a dilated fundus examination does not meet those standards.** It is inappropriate for an optometrist to establish a policy of using retinal imaging or fundus photography for all patients as the only method of examining the fundus. It is also inappropriate to tell patients that digital retinal imaging gives an optometrist the same information as a dilated fundus examination without the inconvenience of the dilating drops.

A patient with diabetes, a patient with symptoms of a possible retinal detachment, a patient with high myopia – these are examples of patients who must receive a dilated fundus examination unless there are contraindications. In these and other situations, you cannot rely on a retinal image as the basis for your diagnosis.

[For more information, see the full policy on Digital Imaging/Fundus Photography in Optometric Practice, and the Optometric Practice Reference (OPR) document 6.2: Ocular Fundus Examination, both available on the College website at www.collegeoptom.on.ca]



Keeping Up to Date after Registration

How does the legislation apply to your daily practice?

Remember the Ontario Optometric Jurisprudence Exam? The one you had to pass as a requirement for registration? If you've been registered with the College for more than a year, the legislation has changed since you took that exam. If it's been several years since you became a member of the College, the legislation has changed a lot, as have some of the administrative and clinical policies and guidelines published by the College. Some changes, like the amendment to the *Optometry Act* that will authorize members to prescribe drugs once the enabling regulations are in place, receive a lot of attention. Other changes, such as a modification to the mandatory reporting requirement for employers of regulated health professionals, have been published by the College but are less likely to be remembered.

But it's not just about being aware of changes to the legislation, it's also about remembering the regulatory requirements that *haven't* changed. To that end, we will be using a Daily Practice column in the Bulletin to remind you about the regulations that are most likely to affect your day-to-day practice. This issue of the Bulletin has an article related to mandatory reporting under the *Highway Traffic Act*. Future issues will include articles related to other mandatory reporting requirements as well as advertising, business practices, recordkeeping etc. Our goal is to keep you up to date, help you to avoid problems in your practice and ensure you understand your rights and responsibilities as a member of the College.

Daily Practice:

Reporting a patient who shouldn't be driving

Under the *Highway Traffic Act*, "every member of the College of Optometrists of Ontario shall report to the Registrar [of Motor Vehicles] the name, address and clinical condition of every person sixteen years of age or over attending upon the optometrist for optometric services who, in the opinion of the optometrist, is suffering from an eye condition that may make it dangerous for the person to operate a motor vehicle."

The current vision requirements for the issuance of a driver's licence (to be met with or without the aid of corrective lenses) are:

Private Passenger Vehicles (Classes G, M)

- 20/50 with both eyes open and tested together
- 120° continuous horizontal visual field, 15° continuous vertical visual field with both eyes tested together

Commercial / Bus Vehicles (Classes A - F)

- 20/30 with both eyes open, tested together -- worse eye no poorer than 20/100
- 150° continuous horizontal visual field, 20° continuous vertical visual field with both eyes tested together

It is important to note that this reporting requirement pertains not only to those persons who currently have or are trying to obtain a driver's licence, but to **any person sixteen years of age or over**. The reporting obligation may arise in a situation where the optometrist is acting as a consultant for such activities as industrial or third party examinations or assessments. There is a waiver/individual assessment program for class G, G1, G2 applicants or holders who do not meet the horizontal visual field standard.

In addition to reporting patients who do not meet the legislated vision requirements for the class of driver's licence they hold, optometrists are also responsible for reporting any person with "an eye condition that may make it dangerous for the person to operate a motor vehicle." This means that even if the patient meets the vision requirements noted above, if an optometrist determines that they have an eye condition that makes it dangerous for them to drive, a report must be made.

Mandatory reports under the *Highway Traffic Act* must be made in writing and sent to the Registrar of Motor Vehicles at the Ministry of Transportation. Report forms are available by contacting the Ministry. Although the Act does not specify a time period in which the report must be made, it should be done as soon as possible after the information is obtained.

The Personal Health Information Protection Act allows for disclosure of personal health information for the purposes of mandatory reporting: the public interest and public safety take precedence over an individual's right to privacy in this situation.

The Ontario Court of Appeal has confirmed that the mandatory reporting requirement of the *Highway Traffic Act* must be complied with even if, in the practitioner's professional judgment, a report is unnecessary. In the past, two physicians were sued for failing to report to the Ministry of Transportation that their patient (shared management) should not be driving. The physicians argued that the patient was aware of his limitations, that they instructed the patient not to drive, and the patient could be trusted not to drive. The patient was, therefore, not a risk, and did not require a report to be filed. The physicians also argued that a practice had developed not to report in every case. They stated that the burden of the broadly worded provision was onerous and impractical, so professional judgment was exercised as to which cases ought to be reported.

The court rejected all of these arguments. The duty to report was mandatory and must be obeyed. It was a duty owed to the public and not just the patient. Failure to fulfill the duty would lead to civil liability where the failure contributes to damage to others. The two physicians in this case were liable, along with others, for more than \$600,000 in damages.

Opportunities to Meet with the College

Local Optometry Society Meetings

At each of these local optometry society meetings, the College will be presenting an update and three hours of continuing education.

September 17, 2010 — Ottawa Valley Society

September 18, 2010 — Sault Ste. Marie

September 24-25, 2010 — Thunder Bay

College Annual Meeting

On October 23, 2010, the College is holding its Annual Meeting in conjunction with the Vision Institute's Fall Conference. The College will be offering three hours of continuing education that will be presented by Dr. Marlee Spafford who will be speaking on Patient Centered Communication.

Tips for improving the doctor/patient relationship

Communicating across cultures

The following 'tips' were developed by the Patient Relations Committee to help members improve their doctor/patient relationship across cultures. This information is available on the College website at www.collegeoptom.on.ca in the Patient Relations section.

1. Culture helps determine the roles for polite, caring behavior and it shapes the concepts of a satisfactory relationship held by both patients and optometrists. Be conscious that there can be cross-cultural differences in the responses to authority, physical contact, communication style, gender and family interactions. For example, these differences can affect the use and interpretation of gestures, hand-shaking, eye contact, facial expressions and colloquial phrases.
2. Consider being initially more formal with patients who are from another culture. In most countries, a more distinct relationship between caregiver and patient is maintained through the relationship. Except when treating children or very young adults, it is best to address patients using their family name.
3. Respect that patients will have different levels of comfort with physical contact. For example, there are significant cultural differences regarding whether to shake hands and how to shake hands. Contact between men and women, even touching an arm to guide patients to the examination chair, are too intimate in some cultures. It may be best to limit physical contact with patients to conducting examination procedures.
4. Consider using a professional interpreter in situations where there is a significant language barrier. In cases where a detailed explanation of the condition and recommended treatment is necessary, an attempt to over-simplify the terminology and/or communicate through the interpretation of a family member may be inadequate.
5. Recognize that patients who do not look you in the eye or ask questions about treatment are not necessarily disinterested. In many cultures, it is disrespectful to look directly at another person (especially one in authority) or to make someone "lose face" by asking him or her questions.
6. Consider that patients may hold different beliefs regarding health, illness and illness prevention. Adopt a line of questioning that will help them express these beliefs. For example:
 - What do you think is wrong?
 - How does this problem affect you?
 - What is your greatest concern about this problem?
 - Do you have any ideas of what should be done about the problem?Be conscious that patients who believe that an illness has been caused by *embrujado* (bewitchment), the evil eye, or punishment, may not take any responsibility for their cure. Belief in the supernatural may cause patients to resist medical advice or treatment.
7. Allow patients to be open and honest about their use of complementary and alternative medicine techniques. The following questions will help to explore this issue:
 - Have you seen anyone else about this problem?
 - What are all the strategies you've used to treat this problem?
 - Who advises you about your health?
8. Be sensitive in relating bad news or explaining the details of complications that may result from a particular course of treatment. Patients from Western culture often will want to make decisions for their own care after being informed about all of their options. Patients from some other cultures, however, may prefer to transfer the responsibility for treatment decisions to the doctor. Watch for and respect signs that patients have learned as much as they are able to or willing to process. If necessary, defer the discussion of additional information to a future visit, and document this in your notes.
9. Describe specific management options in understandable terms, inquire about patients' priorities and then present a reasonable management plan. With patient consent, try to ascertain the value of involving the entire family in the treatment. In many cultures, medical decisions are made by the immediate family or the extended family. If family members can be involved in the decision-making process and the treatment plan, there is a greater likelihood of maintaining compliance throughout the course of treatment.

Do you Treat your Spouse?

(continued from page 1)

The woman filed a complaint with the College of Chiropractors. After an investigation, allegations of professional misconduct, including allegations of sexual abuse, were referred to the Discipline Committee. At the hearing, Dr. Leering argued that there was a “spousal exemption” to the zero tolerance policy and that the mandatory revocation provisions of the legislation did not apply in this situation. This argument was rejected by the Discipline Committee and his certificate of registration was revoked. Dr. Leering appealed the Discipline Committee’s decision.

The Ontario Court of Appeal confirmed the Discipline Committee’s decision: sexual abuse of a patient occurs when a health professional and his or her patient engage in sexual relations – even if the patient is a spouse or the couple is in a spousal relationship. The legislation does not contain a spousal exception. While harsh, given that the relationship was consensual, the Court noted that Dr. Leering could have avoided the situation had he refrained from providing chiropractic treatments to the woman.

Why is there no ‘spousal exemption’? The zero tolerance policy and mandatory revocation provisions in the legislation were influenced by the College of Physicians and Surgeons of Ontario’s *Task Force on Sexual Abuse of Patients* which made recommendations based on the following:

- The general vulnerability of patients in such relationships.
- The power imbalance that almost invariably exists in favour of the practitioner, thus facilitating easy invasion of the patient’s sexual boundaries.
- The privileged position of doctors in society, based on their education, status and access to resources.
- The breach of trust in such conduct by physicians.
- The serious, long term injury to the patient, both physical and emotional, that results from sexual abuse, including harmful effects on future care of the patient.
- The fact that sexual abuse tarnishes public trust in the entire profession.

This is the third decision of the Ontario Court of Appeal dealing with the zero tolerance policy and mandatory revocation provisions. It is important because the Court confirmed the mandatory revocation provisions and clarified that the legislation does not provide an exemption from those provisions even if the patient is the spouse or “significant other” of the practitioner. The message coming from Leering is that optometrists should avoid treating their spouse.



Welcome to our New Members

The College would like to welcome the following individuals who became members between January 1 and April 30, 2010:

Name	Registration No.
Dr. Sameena Gulamali Ahmad	10011
Dr. Curtis Harland Akerman	10025
Dr. Daniel James Black	10027
Dr. Erin Kathleen Bowser	10012
Dr. Kevin David Chung	10021
Dr. Carol W. Fan	10023
Dr. Imran Syed Hussain	10001
Dr. Saleel Jivraj	10004
Dr. Zubin Jiwani	10022
Dr. Samina K. Khan	10013
Dr. Janelle Karen King	10028
Dr. John Newman Mayer	10017
Dr. Sara Mehdizadeh Kashani	10014
Dr. Ihab Fayek Mikhail	10020
Dr. Brandon Mondesir	10006
Dr. Maysoon Raouf	10016
Dr. Shaun Hareh Rawana	10019
Dr. Menka Rughani	10010
Dr. Hadassa Rutman	10018
Dr. Suzan Sarkies	10024
Dr. Weizhi Sun	10026
Dr. Andrea J. Vandendool	10003

College of Optometrists of Ontario Council and Committee Members 2010-2011

Members of Council/ Membres du Conseil

CentralGTA Electoral District/ district électoral du centre

Dr. Debby Lowy
Dr. Dennis Ruskin

Eastern Electoral District/ district électoral de l'est

Dr. Aggie Franzmann

Northern Electoral District/ district électoral du nord

Dr. Shawn Moore

Western Electoral District/ district électoral de l'ouest

Dr. Dino Mastronardi

Provincial Electoral District/ district électoral provincial

Dr. Grace Woo
Dr. Richard Kniaziew
Dr. Thomas Noel
Dr. Derek MacDonald

University of Waterloo/ Université de Waterloo

Dr. Marlee Spafford

Lieutenant Governor in Council/ le lieutenant-gouverneur en conseil

Mr./M. Craig Bridges
Mr./M. Francis Christopher
Mr./M. Geoff Dale
Ms./Mme. Irene Moore
Mr./M. Emad Hussain
Mr./M. Ira Teich
Ms./Mme. Luisa Morrone

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Dr. Dennis Ruskin, Vice President
Mr./M. Craig Bridges, Treasurer
Dr. Thomas Noel
Ms./Mme. Irene Moore

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Dr. Mike Cobean
Mr. Geoff Dale
Dr. Aggie Franzmann
Dr. Dino Mastronardi
Dr. Harvey Mayers
Ms. Luisa Morrone
Dr. Josephine Pepe
Mr. Ira Teich
Dr. David White

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Dr. Catherine Chiarelli
Mr. Francis Christopher
Mr. Emad Hussain
Dr. Deborah Lowy
Dr. Derek MacDonald
Dr. Paul Monk
Dr. Kamy Morcos
Dr. Peter Rozanec
Dr. Patricia Rose
Dr. Dennis Ruskin
Mr. Ira Teich
Dr. Vince Timpano

Discipline/ de discipline

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Mr. Craig Bridges
Mr. Francis Christopher
Mr. Geoff Dale
Dr. Brian Feldman
Dr. Aggie Franzmann
Dr. Jim Hoover
Mr. Emad Hussain
Dr. Richard Kniaziew
Dr. Debbie Lowy
Ms. Irene Moore
Dr. Shawn Moore
Dr. Kan Chhatwal
Dr. Dennis Ruskin
Dr. Susana Sebestyen
Dr. Dino Mastronardi
Dr. Derek MacDonald
Dr. Karin Simon
Mr. Ira Teich
Dr. Grace Woo
Dr. Marlee Spafford
Ms. Luisa Morrone

Fitness to Practice/ d'aptitude professionnelle

Dr. Debrah Lowy, Chair
Dr. Kan Chhatwal
Mr. Emad Hussain

Optometry Review/ de l'étude de l'optométrie

Dr. Greg Simpson, Chair
Mr. Bill Atkinson
Dr. Dagmar Lutzi
Dr. Paul Monk
Mr. Macey Schwartz

Patient Relations/ des relations avec les patients

Dr. Hans Schuster, Chair
Mr. Francis Christopher
Mr. Geoff Dale
Ms. Luisa Morrone
Dr. Karin Schellenberg
Dr. Grace Woo
Dr. Angela Yoon

Registration/d'inscription

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