



## College Successful in Contempt of Court Action

Pursuant to a contempt of court action initiated by the College, the owners of the Great Glasses franchise (Mr. Bruce Bergez et al) have been ordered to pay a fine of \$50,000 a day for every day after November 24, 2006 (the date of the decision of a previous contempt of court action), up to and including October 10, 2007 (the date this latest decision was published). This results in a fine of more than \$15 million. A previous order remains in place prohibiting Great Glasses from dispensing eyeglasses or contact lenses without a prescription from an optometrist or a physician.

### Background

The College has been involved in this case for a long time. In 2003, we were successful in obtaining a court order requiring the owners of Great Glasses to cease dispensing spectacles on the basis of EyeLogic® test results and without a valid prescription. With evidence that the prohibited activity had continued, the College initiated a contempt of court action.

The matter was heard on October 25 and October 26, 2006 and the judgment in the case was released on November 24, 2006. In that judgment, Justice Crane of the Superior Court found that the advertising by Great Glasses was “a gross deception on the public, putting his [Mr. Bergez’s] customers at risk of their health, done solely for the commercial profit of the respondents” and that the business conduct of Mr. Bergez was “highly provocative, arrogant and egregious”.

Justice Crane imposed a fine of \$1,000,000 on Mr. Bergez et al and ordered Mr. Bergez to purge their contempt by posting signs in their stores advising customers that they must have a prescription from an optometrist or physician, and that glasses and contact lenses cannot be dispensed on the basis of the EyeLogic® test performed at their stores. The College was awarded costs.

On December 8, 2006, Mr. Bergez appealed Justice Crane’s decision. Upon filing the appeal, the provision ordering the payment of money (the \$1 million fine) is automatically stayed, however the non-monetary orders must still be complied with.

### Recent Action

After determining that Great Glasses stores continued to dispense eyewear without a valid prescription from an optometrist or a physician, the College filed a new contempt of court action alleging that Mr. Bergez had not complied with Justice Crane’s decision. The case was heard the last week in August by Justice Fedak of the Superior Court. In his decision, published on October 10, 2007, Justice Fedak found that “Bruce Bergez failed to purge his contempt by personally ensuring that dispensing only be done in accordance with a prescription from an optometrist or a physician as mandated by the Judgment of Justice Crane.” This decision has been appealed.

### Upcoming Events

**RoadShow 2007**  
November 17, 2007  
Algonquin College  
Ottawa, ON

**Council Meeting**  
February 6, 2008  
Toronto, Ontario

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# The Word

## Your Profession Needs You!!!

It's not too early to be thinking about Spring. Around the College, Spring means Council elections and setting up new committees. There are three Councillors whose term will end in March 2008. Dr. Michèle Martin from Ottawa (Eastern Region) is completing her ninth consecutive year on Council and therefore must step down. The other two positions are the Northern seat currently filled by Dr. Paul Padfield who pinch-hit for us in a by-election two years ago, and a Provincial seat filled by me. If you have any interest in serving on Council or committees please contact a Councillor or member of the College staff for information.



If you choose not to volunteer to be one of our nine elected Councillors or to serve on a College committee, you have two other opportunities to participate in the privilege of self-regulation. You can vote in the Council elections and you can comment on proposed regulation changes. You can have direct influence on the governance of the profession by voicing your support, questions and/or concerns regarding legislation proposed by the College. With this Bulletin, you will receive a proposal to change the Registration Regulation. Among other proposed amendments, the new regulation would clarify educational requirements for registration and add a provision that would allow resigned members to be reinstated (rather than re-applying as new members). Recently, you should have received the proposed Designated Drugs Regulation along with a change to the Prescribed Diseases Regulation and a proposed Standard of Practice for Glaucoma treatment.

Although both regulation changes are important, the TPA package is certainly the most exciting since it will allow optometrists in Ontario to practice to their full scope as stated in the RHPA (remember this from your jurisprudence course?):

### **Scope of Practice**

*The practice of optometry is the assessment of the eye and vision system and the diagnosis, **treatment** and prevention of:*

- disorders of refraction
- sensory and oculomotor disorder and dysfunctions of the eye and vision system; and
- prescribed diseases.

We want your feedback. If you support the proposed changes, or even if you don't, please let us know. Although this is not a vote, the Ministry of Health wants to know how many stakeholders (you) responded and how many supported the proposed changes. We want to know as well if you have questions or concerns. All responses received by the deadline of December 31, 2007 will be considered by the Clinical Practice Committee and hopefully the proposed regulation will be brought back to Council on February 6th for approval. From there, the regulation moves on to the Ministry of Health accompanied by a comprehensive report in which all stakeholder concerns will be addressed. As well, any questions raised during the circulation about how the regulations would be implemented in day-to-day practice will be used in the creation of the guideline to accompany the new regulation. We are as anxious as you are to see these new regulations in place and will certainly continue to put pressure on the Ministry to move this along as quickly as possible. The information package that will be provided to the Ministry with the proposed regulation will include a wait time study commissioned by the College in order to obtain the most up-to-date information possible. If you happen to be selected to participate in the study, please give it serious consideration as we believe the results will prove to be an important component in support of our position.

### **RoadShow 2007**

Thank you to all who chose to participate in our RoadShow 2007 presentations. The discussions were lively and interesting. It is great to see members passionate about their profession. The diversity of opinions expressed about professional standards reinforced the importance of documenting those standards. In optometry, where many members practice solo, meetings where members can meet colleagues to discuss common practice issues are valuable and I would say even necessary as standards continue to evolve.

I just spent a "refreshing" weekend with over 450 optometrists at three days of TPA continuing education. With TPA practice on the horizon, there was a definite enthusiasm in the room with intelligent questions and interesting discussion. I have no doubt that we are more than ready for this change.

I wonder what my first script will be. Should we have an office pool? My bet would be on an anti-allergy medication. Any takers??

Linda Bathe, O.D.

# Complaint Summary

## Unnecessary prescription

The Complaints Committee periodically receives a complaint that affords them the opportunity to provide information to the complainant on a particular aspect of optometric care. This was one such case, where a mother was concerned that her daughter had been prescribed glasses unnecessarily.

### The Complaint

The College received a letter from the complainant stating that an optometrist had prescribed glasses for her daughter to correct farsightedness, even though her daughter did not have any symptoms or complaints of poor vision. The complainant wrote that her daughter did not like to wear her glasses and always maintained that she could see fine without them. The complainant trusted the optometrist's opinion and encouraged her daughter to wear the glasses despite her claims that she did not need them. The complainant's daughter was subsequently examined by an ophthalmologist who asked why she was wearing glasses, as in his opinion she did not need them. The complainant was shocked to learn that her daughter had been wearing glasses for five years that she did not need.

### Member's Response

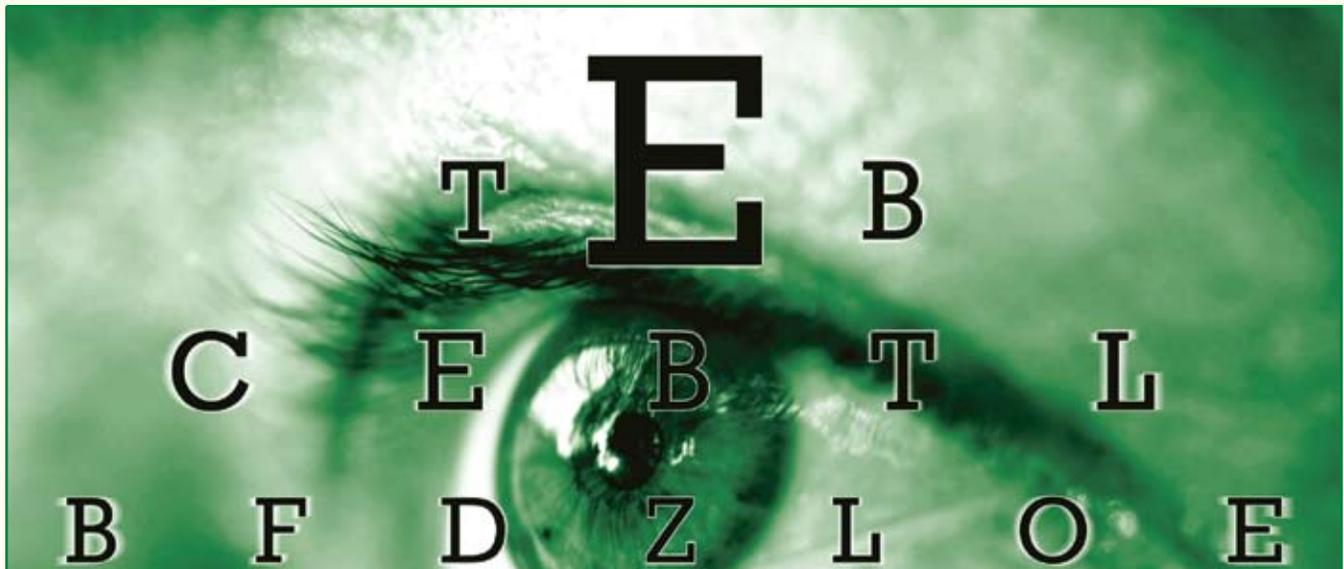
In response to the complaint, the optometrist wrote that she reviewed the patient's file and would recommend the same treatment again. She concluded that since the patient was in Grade 2 at the time the initial prescription was issued, it was best to prescribe eyeglasses so that her ability to learn at school would not be hindered by her farsightedness. The optometrist provided the College with the original clinical record of the care she provided to the patient, as required.

### Committee Review

The Committee reviewed the information obtained in its investigation of the complaint, including a summary of the care provided to the patient by the ophthalmologist. They noted that both the optometrist and the ophthalmologist agreed that the patient was hyperopic. The patient record indicated that the optometrist had performed a cycloplegic refraction and had appropriately reduced the amount found under cycloplegia in the final prescription. The Committee agreed that there were good and sound reasons for the optometrist to take the proactive step to recommend treatment at age seven before the patient became symptomatic. They also noted that the range of hyperopia demonstrated by the patient was high enough that prescribing was indicated. The Committee recognized that by wearing glasses in her early years of development, the patient would experience reduced eye strain when focusing to read, ensuring that the visual information she was taking in while reading was acquired without effort. For the benefit of the complainant, the Committee included quotes from professional literature to support their reasons.

### Decision

The Committee concluded that the optometrist had not prescribed glasses for the patient unnecessarily and took no further action in this matter.



# Three Strikes and We're In

## Abandoned Health Records

By Dr. Ann Cavoukian, Information and Privacy  
Commissioner of Ontario

In May 2007, my office – the Office of the Information and Privacy Commissioner of Ontario (IPC), received a letter from the Royal College of Dental Surgeons of Ontario (the College) stating that they had been contacted by a number of patients of a dentist in the Ottawa area with reports that the dentist's clinic (the Clinic) had closed, without notice. The patients had contacted the College to ask for assistance because of their inability to gain any access to their dental records.

Following these reports, the College made a number of attempts to contact the owner of the Clinic, but with no success. Not having the power or authority to enter the clinic premises in order to seize the records on behalf of the patients, the College contacted my office for assistance.

“...it was of paramount importance to secure the abandoned patient files and to allow patients ... access to their records.”

Based on the information provided by the College, and a personal visit to the Clinic by an IPC staff member, it was confirmed that the Clinic had been closed for some time and appeared to be abandoned. In the ensuing discussions between the IPC and College staff, it was agreed that it was of paramount importance to secure the abandoned patient files and to allow patients of the dental clinic access to their records.

As Commissioner, I decided that, in the absence of any response from the dentist at the Clinic, I would exercise my powers of seizure under the *Personal Health Information Protection Act* (PHIPA), and enter the Clinic premises to take possession of the files. The College agreed to take custody of the files from the IPC, provide secure storage and facilitate access for patients seeking to retrieve their personal health records.

In order to investigate this matter and lay the proper ground work for obtaining possession of the dental records, my office gave written notice – the first of three – to the owner of the Clinic. In the first notice, the owner was advised that: the IPC had initiated a complaint under PHIPA; that the matter was under review; and that a Health Order may be issued.

The notice elaborated on my decision to initiate a review because there were reasonable grounds to believe that the owner of the Clinic had not taken reasonable steps to protect the personal health information that he was responsible for against theft, loss and unauthorized use or disclosure, as required under PHIPA. Further, the owner was, in effect, denying his patients the right of access to their records. In order to ensure compliance with PHIPA and to facilitate access by patients to their dental records, the owner of the Clinic was requested to contact our office immediately to discuss how this matter could be resolved.

After receiving no response from the owner within a set time frame, a second notice was sent demanding that steps be taken to obtain the records and deliver them to my office immediately. With no response to the second notice, I issued a third, and final, notice notifying the owner of the Clinic that my office was intending to enter the Clinic premises and seize all patient records, pursuant to my powers as Commissioner under PHIPA. In my final notice, I provided the date that this would occur and indicated that the records would then be placed in the custody and control of a representative of the College.

Given the possibility that the owner of the Clinic may not have wished to co-operate, I contacted the Chief of the Ottawa Police Service (Ottawa Police) and requested the assistance of the Ottawa Police in carrying out my duty as Commissioner in entering the Clinic. The Chief readily agreed to assist my office in obtaining access to the premises, including making arrangements for a locksmith to be present at the Clinic when entry was to occur and notifying neighbouring businesses of what was about to transpire, so as not to cause any alarm. My utmost gratitude goes out to the Chief, as the assistance and cooperation of the Ottawa Police was critical to achieving the goal of securing the patient records. Not only did the Chief kindly offer his assistance, but he also ensured that a police officer was present at the time of entry, in the event that an alarm had to be disengaged or some other unforeseen circumstances that may have arisen.

On the designated day of entry, an investigator from my office, a representative of the College and a police officer entered the Clinic. The investigator, with the assistance of the police officer and the locksmith, successfully entered and seized the dental records in question. In addition, five computer hard drives, that could have potentially contained additional health information of patients, were also seized, along with a number of dental moulds. Custody of the records, hard drives and dental moulds were immediately turned over to the representative of the College as agreed, who transported them to secure storage at the College's offices in Toronto.

The first step undertaken by the College following the seizure of the records was to notify the patients who had initially contacted the College wishing to obtain their dental records. Following this, the College created an inventory of files and began notifying patients of the Clinic as to the whereabouts of their files and how to gain access to them.

While this is not the first case in Ontario concerning abandoned health records, it is nonetheless a noteworthy incident for my office. This case marked the first time that I exercised my powers as Commissioner under *PHIPA* to enter the premises of a health professional in order to seize patient files. Although it is highly unlikely that I will need to use these powers on anything but an exceptional basis, the exercise proved to be extremely effective in ensuring that abandoned patient files were secure and that patients could exercise their rights of access to their health records.

This investigation is also an excellent example of how different organizations with varying mandates, can work together successfully to achieve a positive outcome. The coordinated efforts of the Ottawa Police, the College, and the IPC were critical to the successful recovery of the dental records of the patients involved in this complaint. I was delighted with the outcome.

## Online Annual Reports

### Electronic payment of Annual Fees

By November 15, 2007, the College will have mailed Annual Report forms and fee invoices to all of our members for 2008. These must be submitted to the College by December 17, 2007. The good news is that the process has now been automated. We recently implemented a secure, password-protected section on our website that will allow members to complete the dues payment and annual reporting processes online. We anticipate that this service will be more convenient for members and will save on the cost of processing payments and report information. In addition, members will be able to update their practice and contact information throughout the year, and view the other information they have submitted to the College (CE hours, practice hours, etc.). Detailed information regarding how to login and complete the process is included with this year's Annual Report.

For many members, providing online payment and reporting has been a long time coming. However, those members who prefer to continue to mail in their completed Annual Report along with a cheque for their fees may continue to do so.

# Discipline Decision

## Dr. Michele Graham, Registration Number 9422

*The following is a summary of the Discipline Committee Decision regarding Dr. Michele Graham. The full Decision may be viewed on the College website at [www.collegeoptom.on.ca](http://www.collegeoptom.on.ca).*

A hearing into allegations of professional misconduct against Dr. Michele Graham took place on May 30, 2007 at the College offices.

The allegation against Dr. Graham was contained in the Notice of Hearing dated November 29, 2006 and was as follows:

1. You committed an act of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code of the Optometry Act, 1991, Statutes of Ontario 1991, Chapter 35 ("Optometry Act") in that on or about April 26, 2006 you were convicted of an offence that affects your fitness to practise optometry contrary to paragraph 49 of subsection 1(1) of Ontario Regulation 859/93 as amended.

Dr. Graham admitted to the allegation as read.

The Statement of Agreed Facts indicated that in February 2003, the College had received information from the Ontario Provincial Police that Dr. Graham was under investigation for alleged fraudulent activity in connection with her billings to OHIP and Green Shield Canada. As a result of this information, the Registrar requested, and was granted by the Executive Committee, the authority to conduct a s.75(a) investigation of Dr. Graham's billing practices.

Dr. Graham and the College presented a Joint Submission on Penalty as follows:

- Dr. Graham shall appear before the Discipline Committee and be reprimanded.
- Dr. Graham's Certificate of Registration shall be suspended for a period of six months, such suspension to be retroactive to the date of her resignation on March 13, 2006.
- Dr. Graham shall pay costs of the hearing in the amount of \$5,000.00 to the College of Optometrists of Ontario, said costs to be payable within 90 days of the date the Discipline Committee renders its decision.
- The terms of the above penalty shall be included in the Register of the College and shall be fully accessible to the public.

# Difficult encounters with patients

By Stuart Foxman

*Published in Dialogue, the magazine of the College of Physicians and Surgeons of Ontario, February 2007. This article is reprinted with permission. Though written with physicians in mind, it provides useful information to optometrists dealing with 'difficult' patients.*

Dr. Michael Cord, a Toronto family physician, once had a patient who habitually left lengthy phone and e-mail messages with his office, sometimes daily, with one demand after another for his time. The patient was never rude to Dr. Cord or his staff, and never disrupted the office, but was “emotionally volatile,” and would exhibit mood swings from moment to moment.

A tough patient to handle? Absolutely. But out of the ordinary? Hardly, says Dr. Cord, who has given workshops on working with difficult patients, via the Ontario College of Family Physicians. He suggests that half the population is capable of being difficult with caregivers under sufficient stressors, and 15-20% are difficult in any circumstances.

With his needy patient, Dr. Cord had to define the caregiving boundaries for himself, and then be consistent. “I made myself as available as I felt was appropriate. But I didn't agree to read the e-mails, or meet outside the office. When dealing with rapid mood changes, you try to be unflappable, and you model emotional containment.”

Every physician has stories of the so-called “difficult” patient, the one who might make your heart sink when you realize they're the next appointment. How should you view and deal with such patients, to make for less stressful encounters? That's the subject of this installment of *Dialogue's* continuing series on communications.

Let's first define “difficult.” We're not talking about patients who are violent (which goes way beyond the category of “difficult”), or merely non-compliant. In surveys, doctors say the toughest patients are those who are manipulative, angry, overly demanding, rude, deceitful, aggressive, uncooperative, disrespectful of their time, and constant complainers.

Dealing with such patients can be draining, says Dr. Gregory Carroll, a psychologist who heads the Institute for Healthcare Communication in West Haven, Conn. “Physicians are highly oriented toward success – that's the culture and their training,” says Dr. Carroll. “When you ask doctors how much time they spend on these [difficult] patients, they would probably vastly overestimate it. But they clearly spend a disproportionate amount of time feeling upset and frustrated, and in some ways, feeling unsuccessful.”

“The essence of a difficult patient,” adds Dr. Cord, “is that if they want to get your goat, they will. If you've acted unprofessionally, the task now is to find a way to restore the patient's trust. This begins with self-reflection on how things got off track.”

So what are some of the methods of handling it? Looking at the literature on the topic, here are 10 of the most effective communication strategies.

## 1) **Be empathetic.**

Patients want you to understand what they're going through. By putting yourself in their place, and imagining their fears, anxiety, concerns, etc., you might get a better feel for why they're coming across as “difficult.” Try saying things like “I understand how you feel,” or “Could you help me understand what you are going through?” Just hearing that can validate the patient, and disarm them if they're coming in upset.

## 2) **Improve your listening.**

Show more patience than you would with other patients, interrupt less, listen without judgment, and offer brief summaries of what you are hearing.

## 3) **Establish a framework for the encounter.**

“Difficult patients often think in a black and white way, which may evoke a black and white response from the doctor. A better response is to recall and stick to one's usual good standard of care,” Dr. Cord says.

## 4) **Be explicit.**

Be clear about what you can offer, and your limitations. Revise the patient's expectations if they are unrealistic.

## 5) **Ensure understanding.**

Repeat back the most important aspects of what the patient tells you, to make sure that you fully comprehend each other.

## 6) **Stay positive.**

Being affirmative and supportive can help you find solutions, and avoids giving fuel to the patient's fire.

### 7) Use “we” language.

By saying things like “As we work together to identify your concerns, we’ll identify common goals and reach agreement,” you emphasize cooperation, and can possibly move away from an antagonistic relationship.

### 8) Remain calm.

Sometime, patients are itching for a fight. If you get drawn into an argument, the patient will then just escalate the confrontation, and any issues the two of you already had will worsen. By speaking and reacting in a calm, reasonable manner, you help patients be calmer too. Don’t get baited.

### 9) Negotiate, don’t dictate.

Difficult patients often test the boundaries of the relationship. But if you dictate those boundaries, you risk being seen as authoritarian. So if the patient is bombarding your office with requests to see you, agree to meet, say, monthly, with a phone consultation in between. Be clear that it won’t help to meet more often unless a new problem arises.

### 10) Clear the air.

Be frank about how the relationship (not the patient) might be problematic. Ask how the patient feels about the care they’re receiving.

Acknowledge the patient’s issues and emotions, and admit your shortcomings. Most important, discuss ways to improve care.

Along with trying communications techniques like these, physicians need to explore their own attitudes towards the patient. This is important, says Dr. Cord, because a difficult relationship may be reflected in the care given the patient. For example, the doctor’s response to such a patient may be to over/under treat the patient or over/under investigate the patient’s concerns.

Dr. Cord says it’s more appropriate to talk about difficult encounters than difficult patients, and about the dynamics of power struggles. If you label patients as difficult, then you’re distancing yourself somewhat from your own emotional reaction. “Talking about these patients in a dismissive way is a way of dealing with the anxiety of dealing with them. But it’s counter-productive.”

In several studies, veteran doctors report far fewer encounters with difficult patients than their less experienced colleagues. This suggests that longer-serving doctors have more experience dealing with a variety of types of patients, and have developed the skills to cope with them.

Regardless of their experience, any two doctors might just perceive the same patient in a different way. Is the patient making a demand or a request? Are they monopolizing your time, or does it only seem that way because it’s late in the day and you’re seriously backed up? Are they really being rude, or are you just being touchy? Are they being aggressive, or are you inattentive because of something that’s happening in your own life?

“It’s an important distinction for the doctor to make,” says Dr. Cord. “Is this a patient who most doctors would find difficult, or who just I find difficult? Do I feel this way with other patients? It’s important for doctors to scrutinize their own personal reaction to their patients, and whether they feel a certain way with particular types of patients.”

It can be useful to talk to colleagues or a peer support group about the patients you perceive as difficult, and your reactions to them. Other physicians might be able to offer insight about how they handle similar situations, or even alter your perception of a patient.

Consider also the patient’s history, he says. Do they have a pattern of difficult relationships? Have they hopped from doctor to doctor? Are they acting out of character? Have your dealings been agreeable until a particular sickness or loss? Understanding all of that can help you negotiate the interaction. Ultimately, he says the best way to provide care to any patient – difficult or otherwise – is to care for the patient.

It’s not always easy. Dr. Cord recalls one patient who dictated the kind of care that he felt he should get, and who wasn’t interested in anything that the doctor had to say. “I felt demeaned by the interaction,” says Dr. Cord. And the patient was a doctor himself!

“What happens is that the patient tosses you a hot potato. But you can’t throw it back at the patient,” says Dr. Cord. “You have to try to find a way back to a compassionate response even when their behaviour threatens to defeat that.”

# Registrar, College of Optometrists of Ontario

EXCELLENCE IN OPTOMETRIC CARE.



The College of Optometrists of Ontario is the self-regulatory body accountable for registering (licensing) and governing optometrists in Ontario. In continuing to “serve the public interest by guiding the profession”, the College remains at the forefront of fulfilling its strategic objectives and effectively delivering results aligned with its vision and mission.

As the chief administrative officer, you will be responsible for the administration of the College by providing strategic and operational support to Council and numerous committees, overseeing the operation of the office and staff, representing the College to its members and a variety of stakeholders, and ensuring that the statutory responsibilities of the *Regulated Health Professions Act* and *Optometry Act* are fulfilled.

You bring an excellent working knowledge of the practice of optometry, government health-care policies and issues affecting optometrists, legislation governing health-care practitioners, including the *Regulated Health Professions Act*, *Optometry Act* and related Acts, and the role of a self-governing regulatory college. You have a comprehensive background in administration and business, including staff and financial management, and in leading a not-for-profit organization and working with a volunteer board. You are a proven leader with a tremendous ability to build internal and external relationships, and communicate with credibility and integrity. You are a clear and critical thinker with an ability to see the bigger picture. You see change management and conflict resolution as an opportunity to drive results forward and further enhance the reputation of the College. This is a fantastic opportunity for a dedicated, passionate professional with a commitment to safe, ethical, high-quality patient care, and a desire to make a wide-reaching difference.

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Please reply in confidence, with a current resume, quoting Project #J5-ES00412, to Knightsbridge Executive Search, at [executivesearch@knightsbridge.ca](mailto:executivesearch@knightsbridge.ca). Alternatively, you may forward your response to: 2 Bloor Street East, 30th Floor, Toronto, ON M4W 1A8. We appreciate your interest and will contact you if a meeting is required.



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## Excellence in Optometric Care

Serving the Public Interest by Guiding the Profession



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