

APPENDIX: W



COLLEGE OF
OPTICIANS
Ontario

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May 15, 2003

Hon. Tony Clement
Minister of Health and Long-Term Care
Minister's Office
10th Floor – Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Honorable Minister:

Re: Standards of Practice for Refraction

I refer to previous correspondence and discussions on this matter, in particular the "mediation session" held at the Ministry on June 27, 2002 and the outcome thereof.

Enclosed, for your information, is a copy of the Standards of Practice for Refractometry approved in principle by the Council of the College of Opticians of Ontario on September 28, 2002. Also attached are copies of correspondence received from the College of Optometrists and the College of Physicians and Surgeons. Both Colleges were asked to review and comment on the Standards.

As you will see, the attached Standards of Practice conform entirely to the so-called "Track One" option identified at the mediation session and they are entirely within the *Opticianry Act, 1991*. It is the College Council's intention, therefore, to lift the prohibition on refraction at the June 25, 2003 Council meeting. Nevertheless, Council would be happy to consider any comments or suggestions relating to the Standards of Practice that the Minister might wish to offer prior to this date.

In addition, at some future point the Council may ask the Minister for a referral to the Health Professions Regulatory Advisory Council (HPRAC). The purpose of the referral would be to have HPRAC review and make recommendations as to whether the *Opticianry Act* should be amended in the public interest in order to allow registered opticians to adapt or adjust prescriptions to reflect the results of refractions, pursuant to standards of practice promulgated by this College.

Yours sincerely,

Cathi Mietkiewicz
President

Encl.

cc: Marilyn Wang, Program Policy Branch, MOHLTC
Robin Martin, Policy Adviser, Minister's Office
Cathi Mietkiewicz, RO, President

Standards of Practice for Refractometry

1. A Member who has successfully completed one of the training programs listed in Schedule "A" and who has professional liability insurance in place covering refraction in accordance with the College's by-laws may perform a refraction on a patient.
2. A Member who performs a refraction on a patient may only dispense an optical appliance (subnormal vision device, contact lens or eye glasses) to the patient after performing the refraction if all of the following conditions have first been met:
 - (a) The patient is a patient of a Member of the College of Physicians and Surgeons of Ontario or the College of Optometrists of Ontario (hereinafter "the patient's prescriber"), and the patient's prescriber has assigned the task of performing the refraction on the patient to the Member.
 - (b) The Member has, with the patient's consent, communicated the results of the refraction to the patient's prescriber; and
 - (c) The Member has received a prescription for the patient from the patient's prescriber or has received the prescriber's authorization to alter the patient's existing prescription.
3. The patient health record for every patient upon whom a member has performed a refraction shall contain:
 - (a) Patient's name, address and date of birth, date refraction took place, and name of Member performing refraction;
 - (b) Identification of the patient's prescriber, including name, business address and telephone and fax numbers;
 - (c) Documentation of the assignment of the procedure to the Member by the patient's prescriber- this may include either a note from the prescriber or a notation by the Member as to how and when the assignment took place;
 - (d) Results of the refraction;
 - (e) Documentation of the communication of the results of the refraction to the prescriber; and
 - (f) Copy of the prescription, or the authorization to alter the prescription.
4. Members who perform refractions on patients are responsible to ensure that they use the appropriate equipment to do so.
5. Members are prohibited from communicating the results of a refraction directly to the patient.

6. Members are prohibited from performing refractions other than in accordance with the provisions of this standard of practice.

7. This standard of practice neither applies to, nor alters, the existing and customary practice of opticians employing over-refraction in order to find the effective prescription for an optical appliance being dispensed to a patient.

DRAFT

Standards of Practice for Refractometry

Schedule A: Recognized Courses of Study for Refracting Opticians

1. Sight Testing/Refractometry Program

Northern Alberta Institute of Technology
Suite 1000, 11762 - 106 Street NW
Edmonton, Alberta
T5G 3H1

(780) 471-6248
Fax: (780) 471-8490
Toll Free within Canada:
1-800-661-4077

2. Opticianry Program

Erie Community College
121 Ellicott Street
Buffalo, New York 14203

716-842-2770
716-851-1189 (V/TDD)
fax: 716-851-1129

3. 100 Hour Refraction Program

The Opticians Association of America
7023 Little River Turnpike, Suite 207
Annandale Virginia 22003

Tel: (703) 916- 8856
Fax: (703) 916- 7966

College of Optometrists of Ontario
L'Ordre des optométristes de l'Ontario

6 Crescent Road, 2nd Floor, Toronto, Ontario M4W 1T1 • Telephone: (416) 962-4071 • Fax: (416) 962-4073
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February 13, 2003

BY REGULAR MAIL TO:

College of Opticians of Ontario
#902 - 85 Richmond Street West
Toronto, ON M5H 2C9

BY FAX TO:

416-368-2713

Attn.: Cathi Mietkiewicz, President

Dear Ms. Mietkiewicz,

Thank you for the opportunity to review and comment on the draft Standards of Practice relating to the performance of refraction by opticians.

As you know, then Minister of Health, Ms. Elizabeth Witmer, in her letter to your College of February 7, 2001, stated that:

“[t]he restriction on opticians' activities [relating to refractometry] must remain in place until the College of Opticians, the College of Optometrists, and the College of Physicians and Surgeons develop effective and enforceable evidence-based standards of practice for the performance of refractometry by opticians that are in the public interest.”

The College of Optometrists and the College of Physicians and Surgeons, as the regulatory bodies of the prescribing practitioners, have adopted the common standard of practice that refraction for the purpose of prescribing can be performed by opticians only under the direct (in office) supervision of a physician or an optometrist. This standard of practice was communicated to the College of Opticians during at least two joint meetings. In addition, a letter signed by the two Colleges and sent to Minister Clement on January 14, 2002, stated:

[b]ecause HPRAC has determined that refraction does not fall within the scope of practice of opticians, nor does the opticians' scope of practice include assessment or the controlled act of prescribing, it is not currently

possible for opticians to conduct refraction and prescribe corrective lenses or glasses to patients without the additional public protection and accountability that would be provided via a cooperative working relationship with health professionals who do have assessment, diagnosis and prescribing within their scopes. However, the necessary accountability and public protection could be provided through the direct supervision of opticians and delegation of the responsibility of refraction.

By developing the standard in the current manner, the College of Opticians appears to be taking an approach different than that which was articulated during our joint meeting in May 2002. From that meeting, it was expected that the College of Opticians would develop standards that recognize that opticians could perform refractometry but not communicate the results to either the patient or any one else. The standards as currently drafted do not respect this limitation.

The draft Standard of Practice that your Council has approved in principle does not recognize the prescribing practitioners' standard of practice that requires direct supervision. Accordingly, it would not meet the Minister's requirement for agreement between all three Colleges before the restriction on opticians' activities could be lifted.

The College of Optometrists considers refraction to be one component of a more comprehensive assessment. When performed for the purpose of prescribing, as your College intends, refraction carries a risk of harm. The College of Opticians implicitly acknowledges this risk of harm by requiring that professional liability insurance be in place covering the performance of refractions by opticians.

The legal advice from Mr. Douglas A. Alderson, that was acted upon by HPRAC in its decision in the refractometry referral, contained the following paragraph:

A public domain activity is, by definition, something which is done with little or no regulation - that's why it is in the "public domain." In addition, public domain activity is, in itself, one which will not cause harm, otherwise it would be a controlled act. However, public domain acts do not exist within a vacuum, they occur in context. In the present discussion respecting regulated health professions, a public domain act, such as herbal medicine or nutritional counselling take on something more than just a public domain act when performed by a regulated health professional. This is necessarily so for a number of reasons. First and foremost is the Harm Clause contained in s. 30 of the RHPA. To be exempt from the Harm Clause, the regulated health practitioner must be performing activity which is within their scope of practice. If that activity falls outside of the scope of

practice, and "serious physical harm" ensues, they will be liable, even if such activity is a "public domain activity."

Exemption from the Harm Clause would be possible if the activity were performed under direct (in office) supervision of the prescribing practitioner. Without this requirement being incorporated into your standard, it is not in the public interest. As such, it would be worth noting that the College of Optometrists, the College of Physicians and Surgeons, and HPRAC have indicated that refraction by opticians would best be dealt with by a review and consideration by HPRAC of an expansion of the scope of practice of opticians.

We are heartened to see that opticians who want to perform this particular task will be required to be educated in the procedure: a sound educational background is a basis for public protection. A list of three approved programs is appended to the draft standards, but no explanation concerning how the College of Opticians decided on these three programs is given. This information would have been useful to us in our consideration. Is it available and can it be provided?

The draft standards of practice appear to apply to opticians only. We would be interested to know what controls will be placed on non-optician employees working in optical dispensaries, and how does the College of Opticians propose to enforce any such controls?

I hope these comments are useful to you in your discussions concerning your draft Standards of Practice for Opticians Performing Refraction.

Best regards,



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

c.c.: Ms. Marilyn Wang, MOHLTC
Dr. Rocco Gerace, CPSO



February 14, 2003

Ms. Cathi Mietkiewicz RO
President
College of Opticians of Ontario
85 Richmond Street West
Suite 902
Toronto ON M5H 2C9

Dear Ms. Mietkiewicz:

Re: Draft Standards of Practice for Opticians Performing Refraction

Thank you for the opportunity to comment on the draft Standards of Practice for Opticians Performing Refraction (the draft standards). The members of the Executive Committee of the CPSO (the Committee) have reviewed the draft standards and asked me to convey their comments to you, as follows.

- The Committee is concerned that the draft standards purport to set out certain roles and responsibilities of the physician (referred to as “the patient’s prescriber” in the standard). Setting appropriate standards for physician involvement with refraction, as with any other professional activity, is the responsibility of the CPSO and not the College of Opticians.
- The Committee wishes to emphasize that any physician involved in issuing prescriptions based on results of refraction performed by another practitioner, should do so in a manner that is in keeping with the CPSO’s policies on Prescribing Outside an Established Physician-Patient Relationship (#8-00) and The Delegation of Controlled Acts (#1-99) [attached]. The Committee notes that although the draft standards use the terminology “assign the task of performing the refraction”, what is actually contemplated is the delegation of that task. The Committee is concerned that there is potential for conflict between the CPSO policies and the College of Opticians’ draft standards.
- The Committee is concerned that the draft standards do not, in fact, reflect “Track One”, the option agreed to during the Ministry-sponsored mediation process. The notes of the meeting of May 27, 2002 prepared by the Facilitator, Margaret Mottershead, state as follows:

Track One: Ended with the optician being able to perform refractometry but nothing more. Opticians could develop standards of practice for the performance of refractometry, however, the only option available to the optician would be to refer the patient to an optometrist or physician without the results of the test.

In contrast, the draft standards define the parameters for allowing an optician to perform the refraction not as a stand-alone action, but rather, specifically for the purpose of dispensing the optical appliance. According to this model, the optician both performs the test and dispenses the optical appliances. The role of the physician (or optometrist) – contrary to

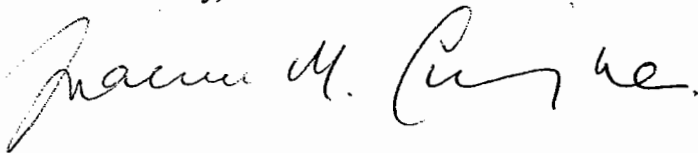
what is envisioned by Track One - is to issue a prescription or authorize a change to a prescription based on the test performed by the optician.

This does not correspond to Track One, which explicitly states that the only option open to the optician is to refer the patient, without the results of the test, to a physician or optometrist.

- During the mediation process, Ms. Mottershead requested that the draft standards of practice to be developed by the College of Opticians be accompanied by a “contextual piece articulating why this position [of the College of Opticians] is in the public interest and how this promotes good eye health”. The Committee notes that no such context has been provided.
- It is not the role of the CPSO to comment on the optician’s proposed standard for record keeping.
- The CPSO is not in a position to comment on the appropriateness of the specific refraction training programs proposed for opticians; however, it would seem preferable that appropriate objectives and end points for educational programs be defined, based upon which various educational programs could be judged.

Once again, the CPSO appreciates the opportunity to review and comment on the draft standards. If we can provide any further assistance, please do not hesitate to contact us.

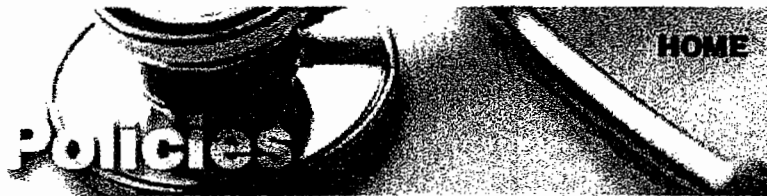
Yours truly,



Graeme Cunningham, MD
President

cc. Dr. Paul Chris, President, College of Optometrists of Ontario

Ms. Marilyn Wang, Program Policy Branch, Ministry of Health and Long-Term Care



**Drugs and Prescribing--
Prescribing Outside an Established
Physician-Patient Relationship**

Policy #8-00

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Drugs and Prescribing](#)
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Approved by Council: November 2000

Publication Date: January/February 2001

To be Reviewed By: November 2003

Key Words: Prescribing, Co-signing, Medication, Drugs

PURPOSE

This policy is intended to clarify the College's expectations of physicians who are asked to sign or co-sign prescriptions for individuals who are not their patients.

SCOPE

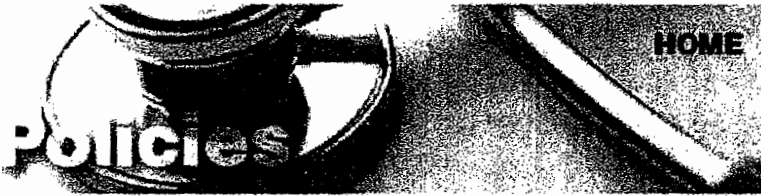
This policy will affect all Ontario physicians.

COLLEGE POLICY

If a physician wishes to sign or co-sign a prescription for an individual who is not his or her patient, basic medical principles of assessment and diagnosis must be applied. It is incumbent upon the physician to obtain an adequate history and perform an appropriate physical examination to reach a diagnosis that will ensure that the requested medications are appropriate. The physician is advised to fully document the encounter.

It is not acceptable for a physician to sign or co-sign a prescription without attending the patient.

Even in cases where this service is provided appropriately, physicians are urged to exercise due caution. Existing diagnostic information about the patient may not be available to the physician providing the service. Furthermore, physicians in these circumstances may not be covered by existing Canadian professional liability insurance and are advised to contact their insurance carrier(s).



The Delegation of Controlled Acts

#1-99

Approved by Council: September 1999

Publication Date: March/April 2000

To be Reviewed By: September 2002

College Contact: Physician Advisory Service

Key Words: Delegation, Controlled Acts, Documentation

Related Topics: Regulated Health Professions Act (1991), Scope of Practice

Legislative Reference: Regulated Health Professions Act (1991), Sections 27, 28, 29, 30

Introduction

The purpose of this policy statement is to assist physicians understand when and how they may delegate controlled acts to another individual.

The purpose of such delegation is to provide higher quality care to patients and to assist physicians in their clinical practice. The College Council urges all physicians to carefully review and comply with these guidelines so that it will not be necessary to formulate more formal regulations.

The Regulated Health Professions Act, which has governed the medical profession since 1993, sets out a number of "controlled acts" which may only be done by regulated health professionals. Of the 13 controlled acts, physicians are entitled to perform 12 and may, in appropriate circumstances, delegate the performance of those acts to other registered health care professionals or to unregistered individuals. Any such delegation should be in accordance with the following guidelines. These guidelines will serve as a reference point for assessing practice if there is concern about a specific circumstance in which delegation occurred.

Guidelines for the Delegation of Controlled Acts

1) Establish the physician-patient relationship

The overriding principle of any delegation is to ensure that the delegation occurs within an established physician-patient relationship. The physician interviews the patient, performs an

relationship. The physician interviews the patient, performs an assessment, makes recommendations, obtains an informed consent to proceed, and institutes a course of therapy. It is within this context that the physician is granted the authority to perform controlled acts on a patient and therefore the opportunity to delegate some portion(s) of the interaction.

If there is not a physician-patient relationship that establishes a right on the part of the doctor to provide care to that patient, the physician should not delegate the performance of controlled acts to other individuals.

There are circumstances within publicly-operated health programs where physicians do delegate controlled acts to others without establishing a physician-patient relationship. Examples include the provision of emergency care in the community by paramedics under the direct control of base hospital physicians, or the provision of primary health care within public health programs. These arrangements have established protocols and built-in checks and balances to provide proper quality control and accountability. This structure of control and public accountability provides a proper basis upon which delegation may occur with good public protection even though there is no traditional physician/patient relationship.

Any physician contemplating delegation outside the context of an established physician-patient relationship should contact the College for guidance.

2) Identify the Controlled Act(s) to be delegated.

It is important for the physician to determine whether the activity or procedure being delegated meets the legal definition of a controlled act. Therefore, identify and be specific about which controlled act(s) is to be delegated. It may turn out that what you are delegating is not a controlled act and is therefore not subject to this policy.

The Regulated Health Professions Act outlines thirteen controlled acts. They are:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of the symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger

- v. putting an instrument, hand or finger,
 - i. beyond the external ear canal,
 - ii. beyond the point in the nasal passages where they normally narrow,
 - iii. beyond the larynx,
 - iv. beyond the opening of the urethra,
 - v. beyond the labia majora,
 - vi. beyond the anal verge,
 - vii. or into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under the RHPA.
8. Prescribing, dispensing, selling or compounding a drug as defined in clause 117(1) of the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

Of the 13 controlled acts, physicians registered in Ontario are entitled to perform 12; the exception is #11, the dental procedures.

3) Delegate only those controlled acts which form part of your regular practice and day to day competencies.

The RHPA requires the physician to confine medical practice to those areas of medicine in which he or she is suitably trained and experienced. Since the physician is under an obligation to delegate the performance of controlled acts only where it is clinically appropriate and necessary in the circumstances, it follows that a physician may only delegate those controlled acts for which he or she personally has the required knowledge, skill and judgement to perform.

Therefore, it would be inappropriate for a physician to delegate to someone else the performance of a controlled act he or she is not capable of performing personally, and which does not form part of his or her regular practice and daily competency.

4) Identify the individual performing the controlled act and be aware of his or her skills.

i) Ensure the individual to whom you are delegating has the appropriate knowledge, skill and judgement to perform the delegated act.

The physician should be satisfied that the individual to whom the act

is being delegated has the appropriate knowledge, skill and judgement to perform the delegated act.

Physicians should not delegate controlled acts where there is a question as to the competence of the delegatee.

ii) Check with the relevant regulatory body of other health professionals where applicable.

Where the individual to whom the act is being delegated is a member of a regulated health profession, make sure the delegation conforms to the regulations, policies and/or guidelines of that health profession. If it does not, the delegatee will not be able to carry out the delegation as directed.

Due regard must be paid to the public safety at all times. Accordingly, physicians may not delegate the performance of any controlled acts to a person whose certificate to practise any health profession is revoked or suspended by the governing body of his or her discipline at the time of the delegation.

iii) Develop written documentation.

The physician should develop written documentation of all steps taken to meet the above guidelines. This document would be a key resource in answering any questions that may arise about the delegation process.

The College recognizes that in some cases particularly within a public hospital setting, the physician may not personally know the individual to whom he or she is delegating. The hospital employs the delegates, e.g. nurses, respiratory technicians etc. and the medical staff are not involved in those hiring processes. It is the institution's responsibility to ensure the competence of those persons.

5) Establish a process for delegation which includes education, ensuring the maintenance of competence in the performance of the delegated act, and providing the appropriate supports.

i) Define the reasons for delegation.

The physician should define the reasons for delegation, including how patient care will be improved.

ii) Identify the risk involved in delegating the act.

Some procedures in some circumstances carry sufficient risk that they should only be performed by a physician. This is a key concept of the controlled acts model. The physician should analyse the potential harm associated with the performance of a controlled act and be satisfied that delegating the act does not increase the risk to

and be satisfied that delegating the act does not increase the risk to the patient. Vital in this process is consideration of the setting in which the procedure will be performed. Also, the physician should be aware of any general restrictions, conditions and/or contraindication to performing the delegated act.

iii) Develop appropriate education materials.

If the activity being delegated is an ongoing part of the process of delivering health care, the physician should ensure that appropriate educational material is available to support the personnel receiving the delegation, that the material is kept up-to-date, and that there is an objective assessment of the knowledge and ability of the delegatee.

iv) Ensure appropriate resources and equipment are available.

The physician should ensure that appropriate resources and equipment are available on site where the delegated procedure is being performed. In the risk analysis certain resources will be identified as necessary for reducing risks. This is important to maintaining public safety.

v) Ensure there is an ongoing quality assurance mechanism.

If the delegation is an ongoing part of the process of delivering care, the physician must ensure there is an ongoing monitoring and evaluation process of the delegation and its outcomes. Improvements to the process can be made as deemed appropriate by the individuals involved.

vi) Develop written documentation.

The physician should develop written documentation of all steps taken to meet the above guidelines. This documentation would be a key resource in answering any concerns or questions about the delegation process in place.

6) Ensure delegation occurs with the informed consent of the patient where feasible.

Physicians should be aware of the increased duty to obtain an informed consent and to make full disclosure to patients in circumstances where the procedure will be done by a non-physician. Physicians should make all reasonable efforts to satisfy themselves that the patient is made aware of the true qualifications of the person performing the act and that the consent to this procedure is informed and based on fair disclosure.

The patient's consent should be documented on the medical record.

7) Ensure proper supervision of the delegation.

A physician delegating a controlled act to another party should provide the appropriate level of supervision to ensure that the act is performed properly and safely. The amount and nature of the supervision will vary with the assessment of risk by the delegating physician. The assessment should take into account the circumstances under which the procedure will be performed, the qualifications of the person performing it, and any specific risks which are associated with the performance of that act.

It is important to remember that at all times, the accountability and responsibility for the delegation of the controlled act remain with the delegating physician. The responsibility for the performance of the controlled act also remains with the delegating physician unless the individual performing the controlled act is a regulated health professional and is authorized to perform the act.

8) Consider any liability issues which may arise from delegation.

The physician might wish to be aware of whether or not the person to whom the controlled act is being delegated is appropriately covered by insurance or otherwise in a position to meet any liability which may arise from the performance of the delegated act. The Canadian Medical Protective Association can provide advice on this matter.

9) Consider any billing issues which may arise from delegation.

Physicians should be aware that the Schedule of Benefits of the Ontario Health Insurance Plan (OHIP) contains particular provisions as to the circumstances under which remuneration can be claimed from OHIP by physicians for the performance of acts which have been delegated to others. Physicians who bill OHIP and who are considering delegating controlled acts to others to improve the quality of patient care should carefully review the provisions of the Schedule of Benefits in this regard. The Ontario Medical Association and the Provider Services Branch at OHIP are available to answer questions and give advice about such matters.

Individual circumstances may be complex. For further assistance or advice please contact the Physician Advisory Service at the College.