COLLEGE OF OPTICIANS OF ONTARIO

SUBMISSION

TO

THE HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL

APRIL 29, 2005

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1.0 INTRODUCTION

On February 7, 2005, the Honourable George Smitherman, Ontario's Minister of Health and Long-Term Care, requested the advice of the Health Professions Regulatory Advisory Council (HPRAC) on a number of issues regarding the regulation of various health professions under the authority of the *Regulated Health Professions Act* (RHPA).

This submission will address the issues relating to Opticianry that were referred to HPRAC. Specifically:

> "Whether there is a risk of harm in dispensing eye wear and what aspects, if any, of this activity need to be controlled by the RHPA, whether refractometry is within the scope of practice of opticianry, and how standards should be set and measured for both of these activities."

This component of the referral consists of five individual, but inter-related, issues.

- Is there a risk of harm in dispensing eyewear?
- What aspects of dispensing should be a controlled act under the RHPA?
- How should standards be set and measured for dispensing eyewear?
- How should standards be set and measured for refractometry?
- Is refractometry within the scope of practice of opticianry?

Each of these issues has undergone a lengthy examination within the eye care professions over the course of the past number of years.

This submission includes an explanation of the profession of Opticianry, defines eyewear, discusses the dispensing of eyewear and refractometry.

The College of Opticians of Ontario (COO) respectively suggests that as the question of whether refractometry is within the scope of practice of Opticians was asked of HPRAC and answered by HPRAC in 2000, this referral should have addressed the question of whether refractometry should be within the scope of practice of Opticianry. This submission will, in addition to addressing if refractometry is within the scope of practice of Opticians, address the question whether refractometry should be included in the scope of practice of Opticianry and will provide suggested amendments to the *Opticianry Act.*

The COO believes that there is a risk of harm in dispensing eyewear and that all aspects of the dispensing of eyewear should continue to be a controlled act under the RHPA. Standards of Practice for both the dispensing of eyewear and for the performance of refractometry have been developed by the COO and should continue to be set and measured by the COO. The public interest is best served

by allowing Opticians to perform refractometry and adapt prescriptions based on the results of the refraction, in accordance with the Standards of Practice established.

2.0 LEGISLATION AND SELF-REGULATION

The rationale for all legislation that regulates health care professionals is public protection. Protection of consumers of health services from practitioners who are untrained or who are found unfit to practise is paramount. This was the rationale for the regulatory statues that preceded the RHPA in Ontario and was an important part of the philosophy behind the RHPA. The public protection rationale is premised in the belief that regulated professionals deliver better health care, which means safe, high quality, effective and technically proficient care. Through the proclamation of the RHPA, the government chose to preserve and enhance self-regulation through Colleges accountable to the public.

The RHPA was enacted on recommendations made by the Health Professions Legislation Review (HLPR), or Schwartz Commission, a task force independent of the Ministry of Health. After being appointed in 1982, the task force took almost ten years to conduct a review and report its findings and recommendations. The RHPA speaks to all aspects of health care delivered by professionals, including which health professions are regulated and what their scopes of practice and protected titles are, which health care acts and procedures may be performed only by regulated professionals, what the powers and duties of the governing bodies are, how to register as a health care professional including what rights and remedies are available to unsuccessful applicants, how to complain about a regulated health professional, how to obtain funding for therapy necessitated by sexual abuse on the part of the regulated professional, what obligations are borne by individuals and institutions that employ or grant privileges to health professionals and what the professional obligations of regulated practitioners are.

The legislation imposes reporting mechanisms on individuals and organizations employing regulated health care professionals, and it requires those individuals and organizations to permit investigators and assessors to inspect patient records and the premises in which regulated professionals practise. In addition, standards of practice and record-keeping requirements set by governing bodies indirectly influence the working conditions and the policies and procedures of employers and managers of health care professionals.

Both the *Regulated Health Professions Act* and the profession-specific health Acts contain restrictions on the use of professional titles and on representations made regarding professional qualifications. The purpose of theses restrictions is to enable consumers to distinguish one health care provider from another, and from those who are not registered health care providers.

One of the most important aspects of regulation is the right to have a complaint registered against a health care professional investigated by the regulatory college. This ability triggers the oversight function of a college, ensures public accountability and the ability to govern members of the profession. The process also identifies areas of weakness in members and offers the opportunity to address the greater membership through continuing education.

3.0 THE ROLE OF THE COLLEGE

The self-regulatory health colleges in Ontario are regulatory agencies created under the RHPA which includes the Health Professions Procedural Code (the Code), and the 21 profession-specific acts. Colleges were created by statute to protect the public from harm caused by members' incompetence, incapacity or professional misconduct, including allegations of sexual abuse, insurance fraud, drug abuse, boundary violations and other breaches of the standards of practice of the profession.

Colleges are the only bodies that can grant and revoke certification or licensure of health care practitioners. Colleges can and do prosecute members for professional misconduct violations. In order to carry out their regulatory role and to ensure the effectiveness of these critical public safety functions, Colleges rely on the collection, use and disclosure of information from sources such as hospitals, long-term care facilities and other health care professionals as provided for under the RHPA.

Colleges were created by the Minister of Health and are accountable to the Minister and to the public in carrying out statutory objects, which include:

- Regulating the practice of the profession and governing the members in accordance with the specific health profession legislation, the Code and the *RHPA* and the regulations and by-laws. The Colleges establish professional conduct standards and investigate and prosecute allegations of professional misconduct, incapacity and incompetence.
- Registering qualified individuals for practice in Ontario's regulated health professions.
- Establishing and maintaining quality of care programs to improve the practice of the profession and setting relevant standards of practice.

In sum, the role of the regulatory colleges' is to protect and safeguard public safety by ensuring that health care is provided by competent and accountable health care practitioners in an effective, safe and ethical manner.

The COO is responsible for, among other things, regulating the practice of the profession, governing its members in accordance with, and administering the provisions of, the RHPA, the Code, the *Opticianry Act, 1991,* and the regulations and by-laws. The COO develops, establishes and maintains standards of practice for the profession. The Complaints Committee and Discipline Committee are two mechanisms for achieving these objects. Section 17 of By-Law Number 21 of the COO creates the College's Unauthorized Practice Committee which deals with persons who are not members of the COO who breach the RHPA and the *Opticianry Act, 1991*. The Unauthorized Practice Committee reviews complaints, allegations and evidence received by the COO about individuals, corporations or other entities, which may have violated the RHPA or the *Opticianry Act, 1991*. The Unauthorized Practice Committee may conduct, or cause to be conducted, an investigation of a complaint or allegation regarding entities or individuals which are not registered members of the COO. Where the situation so warrants, the Unauthorized Practice Committee, with the authorization and approval of the Executive Committee, will commence prosecutions of these persons, corporations or entities for breaches of the RHPA or the *Opticianry Act, 1991*. The COO

seeks to protect the public by governing its members through the complaints and discipline process and by prosecuting non-registered persons, the employers of non-registered persons, and the directors of the corporate employers of non-registered persons.

4.0 WHAT IS AN OPTICIAN?

Opticians in Ontario design and dispense eyeglasses, contact lenses and sub-normal vision devices such as low vision aids and prosthetic ocular devices. Opticians are non-medical professionals trained in the theory and practical application of ophthalmic optics. They fill prescriptions for corrective lenses issued by Physicians (i.e. Ophthalmologists) and Optometrists. Opticians also educate and advise consumers about product choices to provide maximum visual acuity. Other health profession analogies include Pharmacists (who dispense drugs based on a prescription, but counsel patients on alternative products, usage, etc.) and Dental Hygienists or Nurses (who may provide their authorized acts pursuant to an order from a member of another health profession).

The COO acts in accordance with the RHPA and the *Opticianry Act, 1991.* The COO has developed a comprehensive set of Standards of Practice for Opticians. There are currently 2,300 Members registered with the College, which includes Opticians, Student Opticians enrolled in an approved educational program, and Intern Opticians who have completed their education and are currently in the process of completing the national registration examination.

According to the *Opticianry Act, 1991* (the Act) Opticians are authorized to dispense subnormal vision devices, contact lenses or eyeglasses (Section 4). However, Section 5(1) of the Act states that Opticians can only dispense such devices upon the prescription of a Physician or Optometrist.[1] As a result, Opticians work closely with these professionals within the healthcare system.

Opticians practice in a variety of settings. Although a certain percentage practice in Optometrists' offices, Physicians' offices, clinics or hospitals, the vast majority are employed in non-regulated environments. These include practitioner-owned businesses, independent dispensaries, chain stores, and non-dispensary settings such as eyeglass manufacturing laboratories or wholesale suppliers of ophthalmic appliances and accessories. Opticians are not, nor should they be, under the supervision of other regulated professions. The quality and safety of Opticians performance as healthcare providers is ensured by the regulatory regime that exists under the RHPA.

Opticians are front line health care workers, providing among other things a screening mechanism for members and the public not readily available by any other means. Due to easy accessibility and the fact that most Opticians do not require individuals to make appointments to see them, Opticians are well placed to discuss eye care issues with the public. An Optician's dispensary is often the first place members of the public go when they find they are experiencing visual problems.

[1] Ophthalmologists are medical doctors specifically trained in the diagnosis and treatment of eye disorders. Ophthalmologists perform complete ocular visual assessments and some also perform refractions. Ophthalmologists are authorized to perform the controlled act of "prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers". The College of Physicians and Surgeons of Ontario (CPSO) regulates Ophthalmologists.

Optometrists are non-medical professionals (like Opticians) who are authorized to assess the eye and vision system, as well as diagnose, treat and prevent disorders of refraction; sensory and oculomotor disorders and dysfunctions of the eye and vision system.

Optometrists are authorized by their Act, among other things, to prescribe as well as dispense subnormal vision devices, contact lenses or eyeglasses. Optometrists are also authorized to perform full oculo-visual assessments which include refracting and prescribing on the basis of the refraction. Like Medicine and Opticianry, Optometry is a self-governing profession regulated by the College of Optometrists of Ontario.

Opticians often see their patients several times during each year; beginning with the initial fitting of eyewear, and throughout the year for follow-up adjustments. Opticians help consumers decide if a new refraction is necessary or if using their existing optical prescription will suffice. Opticians answer consumers' questions on a broad range of eye care issues for everything from dry eyes to refractive surgery and refer to other eye care professionals as appropriate.

5.0 OPTICIANRY EDUCATION

A person seeking to register as an Optician in Ontario must successfully complete and graduate from an Ontario Opticianry program approved by the Ministry of Training, Colleges and Universities, or an Opticianry program which is deemed equivalent by the Registration Committee of the COO. Where a person is licensed or registered to dispense eyewear outside of Canada or is engaged in the practice of dispensing eyeglasses or contact lenses in a jurisdiction outside of Canada that does not require licensure or registration, that person may be accepted for registration provided that the Registration Committee is satisfied on evidence presented that she or he has a level of knowledge and skill in the practice of Opticianry that is equivalent to that acquired by graduates of an accredited academic program in Ontario.

Seneca College of Applied Arts and Technology and Georgian College are the two colleges in Ontario whose Opticianry programs are accredited by the Ministry of Training Colleges and Universities. Copies of the curriculum for the Opticianry program at each of Georgian College and Seneca College are attached.[2] The teaching colleges design their programs and teach to the COO approved "Entry to Practice Competencies for Opticians in the Province of Ontario".[3] These competencies were developed in consultation with the teaching colleges and other appropriate stakeholders and were approved by Council in June 2003. The COO is currently developing Entry to Practice Competencies for refraction. A draft has been approved, in principle, by the Council of the COO and has been made available to stakeholders for comment. Once all the comments have been reviewed the Competencies working group will present an amended draft for Council approval. Subsequent to approval, the teaching colleges will incorporate the complete refracting competencies into their curriculum. We have attached the draft for your information[4], but reiterate that this document is currently in the drafting stage. Also attached are copies of the comments on the draft refracting competencies from the College of Physicians and Surgeons and the College of Optometrists.[5]

Currently there are two major components to the Opticianry programs approved in Ontario; the theoretical and the practicum.

In the theoretical and background knowledge components, required courses include physical, visual, ophthalmic and geometric optics, anatomy, physiology and pathology of the eye and adnexa, eyeglass dispensing theory, contact lens dispensing theory and jurisprudence. In the optics courses, students explore mathematical models and concepts using mathematical calculations to solve problems involving optics. The students are taught all aspects of the continuum of dispensing of eyeglasses, contact lenses and low vision aids. The students study the anatomy and physiology of the eye and the ocular pathologies and the systemic diseases that affect vision. They are taught to identify ocular conditions and refer patients for appropriate medical attention. Recognition of pathology is a mandatory requirement of the profession as Opticians must be able to identify

[2] Georgian College and Seneca College Curriculum (Appendix A)

[3] COO Entry to Practice Competencies in the Province of Ontario (Appendix B)

[4] COO Draft Refracting Competencies (Appendix C)

[5] Comments on Draft COO refracting competencies from CPSO and College of Optometrists (Appendix D)

problems, determine their significance and refer patients to the appropriate health care professional in the proper timeframe.

Students are required to successfully complete laboratory and clinical courses in eyeglass dispensing contact lens dispensing and eyeglass fabrication. In the dispensing laboratory courses, students learn how to take frame and facial measurements, to perform the alignment of, adjustment to and repair of eyeglass frames, and to select and recommend optical lenses and special features to the benefit of their patients. They also learn how to use various types of instrumentation used in providing vision care. In the contact lens laboratory courses, students learn how to fit, measure, perform manifest over-refraction and dispense contact lenses. In the fabrication courses, students learn how to fabricate eyeglasses and how to verify that the completed eyeglasses meet the required quality standards provided by the COO.

The Opticianry programs at both Seneca College and Georgian College have a practicum requirement that encompasses at least 1000 hours. The student works in a dispensary under the supervision of an Optician, Optometrist or Physician, during which time the student must dispense appropriately, under direct supervision, at least 250 eyeglasses and 20 pairs of contact lenses.

Concepts and principles of refractometry are taught in Ontario as part of the curriculum in the approved Opticianry programs at Georgian and Seneca Colleges. Post-graduate programs in refractometry are available in Ontario through Georgian College and the Northern Alberta Institute of Technology.

The Heads of Opticianry Education in Ontario received and reviewed the Minister's referral to HPRAC and wrote to the President of the COO[6] outlining the educational requirements for Student Opticians. Their belief is that the dispensing of eyewear presents a risk of harm to the public and their position is that dispensing should remain a controlled act under the RHPA. In their view, inappropriate assessment, poor fit, poor choice of materials and poor follow up creates the potential for risk of harm.

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[6] Correspondence from the Heads of Opticianry Education in Ontario (Appendix E)

6.0 NATIONAL OPTICIANRY ORGANIZATIONS

Opticianry is a vibrant, proactive profession that boasts a number of national organizations who contend with Opticianry issues on a daily basis. These national organizations include the:

- Opticians Council of Canada (OCC)
- National Association of Canadian Opticianry Regulators (NACOR)
- National Examination Committee (NEC)
- Opticians Association of Canada (OAC)
- National Committee on Opticianry Education (NCOE)

Membership in the Opticians Council of Canada (OCC) includes representatives from all the provincial regulatory bodies, provincial associations, the national association and all the teaching colleges. Membership in the National Association of Canadian Opticianry Regulators (NACOR) includes representatives from each of the Optician regulatory bodies across Canada. The National Examination Committee (NEC) is a sub-committee of NACOR and encourages representatives from each of the Optician regulatory bodies across Canada to meet to develop and enhance the National examination. The COO was welcomed into this body and has provided meaningful input since the Committee's inception, even prior to the COO adopting the National Exam. The Opticians Association of Canada (OAC) is the National Association for Opticians. The board of directors is made up of association representatives from each province. The National Committee of Optician Educators (NCOE) is comprised of representatives from each educational institute offering Opticianry education within Canada.

Representatives from Ontario Opticianry organizations have been active and important participants in all of the above groups over the years. Ontario is well respected by the other provinces across the country, as evidenced by the fact that President of the Ontario Opticians Association is the elected President of the OAC, and the President of the COO is the elected Chair of NACOR and the OCC.

The COO recognizes its role not as advancing the interests of opticians, but in governing opticians in the public interest, in ensuring that the public is well served by safe practices and the delivery of quality eye care.

7.0 EYEWEAR

Prior to reviewing risk of harm issues it is important to be clear on what constitutes "eyewear".

When some people think of eyewear they think of the ready-made eyeglasses available at any drugstore. These, in fact, are considered by the legislation to be simple magnifiers, the dispensing of which is not controlled by the RHPA.

The COO believes that the sale of these ready-made readers or ready-made bifocals is in keeping with the letter of the law in Ontario, but violates the spirit of health care legislation in Ontario.

Eyewear as contemplated within the legislation includes eyeglasses, contact lenses and sub-normal vision devices. There are too many specific types to list them all, but this submission will highlight the more prominent types.

Eyeglasses

There are several types of eyeglasses that can be dispensed to patients, depending on their individual needs and after a complete review of the patient history; single vision for distance or near, safety eyewear, vocational, sports eyewear, multi-focal, bi-focal, tri-focal, PAL (Progressive Addition Lens), computer/workstation lenses.

Contact Lenses

Contact lens choices include; PMMA (Polymethylmethacrylate), RGP (Rigid Gas Permeable) including multi focal, single vision, scleral, keratoconus; soft lenses including disposable, conventional, toric (conventional and disposable) bi-focal, bandage, and coloured (cosmetic and prescription).

Sub-normal Vision Devices

This category offers a broad range of optical appliances which includes but is not limited to; magnifiers (hand held and head-borne), telescopes (hand held and head-borne), absorptive filters, ptosis crutch, prosthetic eyes, scleral shells and projection systems such as low vision aids.

8.0 DISPENSING

Dispensing is a controlled act under the *Regulated Health Professions Act, 1991*, and is authorized to Medicine, Opticianry and Optometry. The current legislation does not define dispensing as it relates to eyewear.

The Professional Relations Branch of the Ministry of Health proposed a process in which the COO and the College of Optometrists would act as co-chairs of a working group of eye care providers to develop an approach to the specific recommendations 97 and 98 of the Red Tape Review Commission. The final report submitted by the Co-Chairs was in their view "…a description of the appropriate regulatory framework for dispensing which respects the public interest, maintains protection for the public against the level of potential harm inherent in dispensing and reduces 'red tape'".[7]

In the Report both groups agreed that there is a risk of harm in dispensing without regard to the age of the patient or the nature of the device being dispensed.

Although the terminology sometimes varies, the COO uses the term "dispensing", the College of Optometrists sometimes refers to dispensing as "spectacle therapy" or "contact lens therapy". The two organizations were able, during that consultation, to reach a common definition of dispensing eyewear:

> Definition: ***The preparation, adaptation and delivery of eyeglasses, contact lenses or subnormal vision devices to a person.***
> The COO currently has a policy regarding the Dispensing of eyewear.[8] The policy states:
>
> Dispensing includes:
>
> a) interpreting a prescription for,
> b) evaluating or advising a person in respect of, or,
> c) preparing, providing, verifying, adapting, fitting, or duplicating a device for sub-normal vision, a contact lens or a pair of eyeglasses

The COO has a policy that defines dispensing that was developed in response to the decision of Mr. Justice Borins in the case of the College of Opticians of Ontario vs. Karreman et al, Ontario Court of Justice (General Division), August 30, 1995.[9] In his decision Justice Borins defined dispensing as the following:

> "…dispensing for vision or eye problems, subnormal vision devices, contact lenses or eyeglasses…includes;
>
> a) Interpretation of a prescription of a physician or optometrist

[7] Report of the College of Opticians of Ontario and the College of Optometrists of Ontario in Response to the RTRC, May 1998 (Appendix F)

[8] COO Policy regarding the dispensing of eyewear (Appendix G)

[9] Decision of Justice Borins re College of Opticians of Ontario vs. Karreman et al (Appendix H)

b) Provision of advice to a person regarding frame suitability with or without reference to a prescription of a physician or optometrist;
c) Provision of advice to a person regarding lenses and lens coating suitability with or without reference to prescriptions of physician or optometrist;
d) Evaluation of a person's needs with reference to the provision of subnormal vision devices, contact lenses or eyeglasses
e) Taking of all measurements necessary in providing subnormal vision devices, contact lenses or eyeglasses
f) Preparation of the final design of subnormal vision devices, contact lenses or eyeglasses;
g) Verification of completed and/or repaired subnormal vision devices, contact lenses or eyeglasses;
h) Fitting of subnormal vision devices, contact lenses or eyeglasses to the human face, eyes and/or head;
i) The adapting of subnormal devices, contact lenses or eyeglasses to the human face, eyes and/or head
j) Adjusting of subnormal vision devices, contact lenses or eyeglasses; and
k) The provision of follow-up care relating to subnormal vision devices, contact lenses or eyeglasses

9.0 IS THERE A RISK OF HARM IN DISPENSING EYEWEAR?

The Minister of Health and Long-Term Care has requested advice from HPRAC on whether a risk of harm exists in dispensing eyewear.

While this topic may have been an issue years ago, a consensus has long since been reached among all the stakeholders (which is rare in the vision sector) that there is indeed a risk of harm in the dispensing of eyewear. In all of our meetings with the Ministry of Health and Long-Term Care in recent years, including one on the day the referral was issued; the issue has never been raised. Why it is being raised again at this time is perplexing.

The HPLR, which was the precursor to the RHPA, spent six years exploring which modalities posed a risk of harm to human health and concluded, after a full consultative process with input from the public and stakeholder groups, that dispensing does pose a risk of harm. Accordingly, the legislation included dispensing as a controlled act within the RHPA without regard to the age of the patient or the nature of the device being dispensed.

Similarly, in its final report of January 1997, the Red Tape Commission also concluded that dispensing constituted a risk of harm to the public and should remain a controlled act. The Commission went further and recommended to the Minister of Health, that the CPSO, the COO and the College of Optometrists of Ontario, should develop common principles and practice standards for the dispensing of subnormal vision devices.

In the May 1998 report submitted in response to Recommendations 97 and 98 of the Red Tape Review Commission by the COO and the College of Optometrists (see Appendix F) both parties agreed that "... there is a risk of harm in dispensing without regard to the age of the patient or the nature of the device being dispensed." The COO of Ontario still concurs with that position. The risk of harm derives primarily from the performance of the core cognitive functions and behaviors of dispensing. In addition, the College also recognizes that the procedures of dispensing present varying risks of harm.

The core cognitive functions and behavior of dispensing include the determination and recording of the specifications of the eyeglasses, contact lenses, or subnormal vision devices to be provided to a patient; the confirmation and recording of the appropriateness of the eyeglasses, contact lenses or subnormal vision devices to be provided or delivered to the patient; and the provision and recording of the necessary advice, counseling and associated care to the patient about the use of the eyeglasses, contact lenses, or subnormal vision devices.

In 1992 the Health Professions Council (HPC) in British Columbia reviewed whether there was a risk of harm in dispensing and whether Opticians in that province should be regulated under their Health Professions Act.[10] The HPC included in its recommendations to the Minister of Health and the Minister responsible for seniors the following (relevant points):

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[10] 1992 Report of the British Columbia Health Professions Council (Appendix I)

1. the profession of opticianry be designated under the *Health Professions Act*,

3. the title" Optician", whether or not in conjunction with any other word such as "dispensing", be used exclusively by registrants of the College,

4. the services which may be performed by opticians are the dispensing of eyeglasses and contact lenses in accordance with a prescription from an optometrist or a physician,

5. the following limitations be placed on the performance of services by registrants, namely:

   (i) no optician shall fit contact lenses unless qualified to do so by the College of Dispensing Opticians;

6. the fitting of contact lenses shall only be performed by registrants of the College who are qualified to do so and persons authorized under another Act but this restriction shall not apply to the refilling of an existing prescription (without alteration) for replacement contact lenses.

It is the COO's position that only Ophthalmologists, Optometrists and Opticians have the necessary knowledge, skill, judgment and accountability to perform the three core cognitive functions of dispensing safely and competently.

There are risks of injury to members of the public if the dispensing of eyewear is performed poorly. There can be injury to the eye itself. There can be injury to the patient, and to the general public from the impairment of vision caused by an improperly dispensed ophthalmic appliance.

Of the five senses, sight, sound, smell, touch and taste, the brain relies first and foremost on sight to provide cognitive functions. The ability of the brain to assess and evaluate situations, determine courses of action and debate the risks associated with specific courses of action are determined in part by its ability to understand the images transferred from the eye to the primary visual cortex.

Some of the possible risks for patients wearing eyeglasses include; injury to the eye and/or visual system, partial or complete loss of vision, accommodative spasm, induced strabismus, induced ectropion, reduced peripheral vision, induced photophobia, eyestrain and reduced visual acuity. Patients can also experience injury to the face, head, neck**,** infection, bruising, skin perforation, neck pain and hyperextension of the neck and migraine headaches. Patients allergic to certain plastics should not wear contact lenses or eyeglass frames or lenses manufactured from that type of plastic. Patients at risk of being in accidents that might shatter glass lenses should wear plastic lenses, preferably polycarbonate. (Lenses made from polycarbonate, the same type of plastic used for the space shuttle windshield, are about 50 times stronger than other lens materials.) Some occupations, such as construction or auto repair, may require safety lenses and safety frames.

Over the years, experts have discussed and written about the risk of harm in dispensing eyewear. We have attached several articles[11] offering a sampling of the range of expert advice from Opticians, Optometrists, and Ophthalmologists detailing the inherent risk of harm in dispensing.

[11] Articles on risk of harm in dispensing (Appendix J)

Eyeglasses

By viewing objects through the wrong part of the lens, visual acuity will decrease significantly, depth perception will become impossible to determine and peripheral vision becomes blurred and distorted. Each of these functions, visual acuity, depth perception and peripheral vision are critical elements in the performance of daily tasks. The risk of harm to the person and possibly the general public is not only possible, but inevitable if any of these senses are lost while performing tasks such as driving, operating machinery or operating computer stations such as air traffic control centers or factory control systems.

Multi-focals

Multi-focals include traditional lined bifocals and tri-focals and no-line progressive addition lenses (PALs). The correct placement of segments/reading portions is crucial to achieve optimum visual performance from any multi-focal. Additionally, if a multi-focal is positioned incorrectly the patient wearing those lenses will be forced to hold their head, in an unnatural position, putting the spine in an unnatural curvature with the risk of causing painful neck and/or spinal injury.

Safety Eyeglasses

The inherent risks of ocular injuries in industrial settings are self-evident. Care must be taken to recognize the possibility of multiple and simultaneous exposure to a variety of hazards. Safety eyewear must protect the wearer from air-borne particles, such as dust, splash risks including chemicals, hot liquids etc. and impact from flying objects. In addition to the inherent risks comes the added aspect that individuals wearing safety eyewear naturally assume that their eyewear meets all relevant safety standards and they are therefore protected from harm so they act accordingly. The Canadian Standards Association has produced the attached “Users Guide”[12] for fitters to assist them when dispensing safety eyewear. While this guide is useful to safety eyewear fitters and highlights the importance of properly fitted eyewear, it does not take the place of a qualified fitter providing safety eyewear. Adequate protection against the highest level of each of the hazards must be provided.

Sports Eyewear

Sports eyewear comes with its own unique set of risks for ocular injury. The velocity at which a variety of projectiles may impact the lenses must be considered in addition to all the conventional concerns regarding proper fit, measurements, lens options, and so on.

Computer Glasses

As people are spending more time in front of a computer, they are finding that their eyes are focused at a very specific range for long periods of time. Eyestrain and even muscle strains, due to adjusting

[12] Canadian Standards Association “Users Guide” for fitters (Appendix K)

the body to see better, can be avoided with the correct pair of glasses. Computer lenses are designed specifically for the distances associated with computer use: the intermediate and close-up zones. Computer-specific eyewear will provide patients with the best correction for these distances, helping to avoid eyestrain.

Vocational

Some patients find that their regular glasses are adequate for most of their day, but are not quite right for their occupation. For example, if a patient wears bifocals, they may find that they need to tip their head back all day long to use the reading portions in the bottom of the lenses, because what they are reading is not in their lap. Instead of suffering neck discomfort to do this, special glasses for work can be fitted that have the reading segments placed higher up in the lenses.

Driving and Sun Glare

Without adequate protection, sun glare not only endangers drivers' safety, but also creates a vision-health hazard for winter outdoor enthusiasts. There may be an increase in the number of traffic accidents due to motorists being temporarily blinded by the sun, mainly because of the glare from highly reflective snow and ice. Problems associated with glare from the sun while driving are largely unrecognized, but likely affect the vast majority of adults. It also appears that as people age, they become more susceptible to glare and require a longer period of time to recover from exposure to glare.

The danger comes primarily from two different conditions of light from the sun. One occurs when driving directly into the bright sunlight, temporary blinding the driver. The other condition comes from reflected light off of another vehicle, the roadway, or any reflective surface. The glare-induced "blindness" is especially prevalent during the winter months, due to the lower elevation of the sun in the sky and the extremely reflective qualities of snow and ice on the ground. The powerful glare of the winter sun has the potential to damage the eye. Because snow is so reflective, there is a risk of up to 85 percent of the UV rays of the sun being transmitted upward. Poor visibility due to sun glare is the suspected cause of many motor vehicle accidents.

A frequent problem for skiers, snowmobilers and others who spend a lot of time in the intense reflective light of snow is 'snow blindness'. This condition can damage the cornea for up to a week, cause eye pain and extreme sensitivity to light. The reflected UV rays are believed to contribute to various eye diseases such as cataracts, macular degeneration and photokeratitis Patients may also experience blurred vision, change in color vision or difficulty seeing at night.

Contact Lenses

Some of the possible risks for patients wearing contact lenses include, interference with the flow of oxygen, which can cause edema and ulceration which can lead to infection, chemical or allergic reactions to the contact lenses or solutions, contamination of the lenses (microorganisms) can cause serious irritation or infections, ulcerative keratitis that can rapidly lead to blindness and temporary changes in the shape of the cornea that causes interference with vision.

Currently the dispensing of non-prescription cosmetic contact lenses is not regulated. Since they do not contain a prescription Health Canada does not consider them to be a medical device. Despite that designation, Health Canada issued a warning to the public on October 23, 2000 citing serious safety concerns with the use of non-corrective coloured lenses.

Contact lenses, though worn by millions, may result in many potential complications. Most of these problems can be attributed to contact lens over-wear, poor lens hygiene, sensitivity to lens materials or solutions, or a poor fit. People employed in certain occupations may be prohibited from wearing contact lenses, or may be required to wear safety eyewear over the contact lenses. Swimming with contact lenses in may be associated with a devastating ocular infection known as Acanthamoeba keratitis.

Contact Lens Solution Hypersensitivity

Hypersensitivity to contact lens solutions may occur. Patients usually present with red, irritated eyes and difficulty wearing the contact lenses. Usually the patient has recently changed contact lens cleaning or storage solutions.

Tight Contact Lens Syndrome

Tight contact lens syndrome occurs when a contact lens is ill-fitting. Because of a variety of factors, including tear film deficiencies and changes in corneal curvature with contact lens wear, a tight contact lens syndrome may occur even in patients with initially well-fitting contacts. The patient usually complains that the lens feels fine until after a few hours of wear, at which point it becomes uncomfortable. The eye may also become red. The symptoms usually resolve within a few hours after discontinuance of contact lens wear.

Tight contact lens syndrome shows a contact lens that scarcely moves on the cornea with blinking. Resolution of the problem entails fitting a contact lens with a flatter base-curve or smaller diameter. In essence, the lens must fit more loosely on the eye, allowing the tear film better access to the cornea beneath the contact lens.

Bacterial Infectious Keratitis

Microbial keratitis is a potentially devastating complication of contact lens wear. The eye is under constant threat of infection by bacteria present on the lids and in the tears. Fortunately, the eye has many defense mechanisms with which to fend of the bacterial invaders.

The lids constantly wipe the ocular surface, mechanically dislodging bacteria and epithelial cells from the surface. The constant flow of tears across the eye continually washes away bacteria and debris from the eye and into the nasolacrimal ducts. The tears not only have a diluting effect but also contain immunoglobulin, lysozyme, and compliment, which can inactivate potential pathogens.

The multiple layers of epithelial cells provide a formidable barrier to bacterial infection. The mucin-coated surface is resistant to bacterial adhesion. The constant shedding of desquamating epithelial cells rid the eye of attached bacteria. The multiple layers of epithelial cells give the ocular surface

extra security. If one layer of cells is penetrated, it can be sloughed, while the remaining layers remain to provide continued protection.

The cornea is richly innervated with sensory nerves, which respond to bacterial toxins, inflammation, and epithelial defects. The resulting pain increases tearing and blinking resulting in increased protection.

All of these protective mechanisms are affected adversely by contact lens wear. The contact lens is a barrier between the epithelial surface and the lid preventing the wiping action of the lid. Tear exchange is reduced markedly under the contact lens, creating a stagnant pool of tears next to the cornea.

Contact lens wear reduces the thickness of the epithelium, the rate of cell turnover and desquamation, and increases the ability of bacteria to adhere to epithelial cells. With the reduced corneal sensitivity associated with contact lens wear, the early stages of infection may not be felt as much; thus, the reflex tearing and blinking responses may be blunted.

Contact lenses also cause breaks in the epithelium (punctate erosions, abrasions, and splits), which allow direct access of pathogens to the stroma. The epithelium of the contact lens wearer is thinner, less sensitive, and relatively hypoxic; all of these factors reduce the ability of the epithelium to repair itself and repel invading organisms.

The introduction of disposable lenses did not reduce the risk of infection; in fact, the risk of infectious keratitis in disposable lens wearers was increased relative to daily wear soft or gas-permeable lenses. More recent studies also have found the risk of microbial keratitis to be increased with disposable contact lenses even when other risk factors were controlled. However, the primary risk factor for developing contact lens–related bacterial keratitis is sleeping with the lenses in. Similar to cosmetic contact lenses, aphakic extended wear increases the risk of infection.

Corneal Warpage

Corneal warpage is a condition that may develop with hard, rigid gas-permeable, or soft contact lenses. The condition is characterized by an unusual change in the curvature of the cornea with contact lens wear. The cornea is literally "molded" by the contact lens into a distorted shape. The condition usually presents with gradual worsening of vision while wearing contact lenses, need for frequent lens power changes, and in some cases, an irritated, red eye. The condition can only be assessed with use of a keratometer or a corneal topographer, both of which determine the shape of the cornea. The only available treatment is discontinuance of contact lens wear until the cornea stabilizes (usually a few weeks or months). Contact lenses may be refit once the cornea is stable; however, recurrence of corneal warpage is likely. The patient is usually informed that eyeglasses or, perhaps, refractive surgery may be better options depending on the degree of refractive error.

The tear film

The tear film provides a smooth and transparent refractive surface, essential moisture, and oxygen to the epithelial cells. Tears also contain immunoglobulins and other proteins, which help protect

against infection. The health of the ocular surface is entirely dependent upon an adequate quantity and quality of tear film, both of which can be altered by the presence of contact lenses.

Bacteria and debris are collected in the tear film, wiped by the lid blink, and rinsed away from the surface of the eye. The presence of a contact lens on the eye substantially reduces the interchange of tears across the ocular surface. Rigid lenses reduce the tear exchange compared to no contact lens wear. Soft lenses reduce the tear exchange to an even greater extent and the larger the diameter, the greater the reduction.

The effect of contact lenses on the tear film can vary from one part of the cornea to another part of the cornea. Tear film instability exists in the interpalpebral fissure in the periphery of the cornea, the so-called 3- and 9-o'clock areas, in wearers of rigid contact lenses. It is typical for rigid lenses to produce corneal staining at these sites. Epithelial damage in these areas is associated with instability and abnormalities in the mucin layer of the tear film.

In addition to the mixing of tears, the content of the tears can be altered by the presence of contact lenses. Overnight wear increases the levels of tear proteins compared to daily wear or no wear of contact lenses.

Rigid Gas Permeable Lenses

A rigid contact lens can dislocate from the cornea and settle into the upper fornix. Eventually, the lens may erode through the conjunctiva and enter the soft tissues of the lid where it can remain relatively asymptomatic. Alternatively, the tissues around the contact lens can become irritated and inflamed producing a sterile abscess. The lens foreign body can incite the formulation of granulation tissue around the lens, encapsulating it in a cyst like structure. A mechanical ptosis occasionally is the result of the mass of lens, scar, and fibrous tissue in the lid. An embedded contact lens also can produce enough scarring and contraction of the lid tissues to produce a lid retraction. The contact lens need not migrate into the lid tissues to produce ptosis. A ptosis lid can result simply from severe giant papillary conjunctivitis (GPC).

Often, ptosis can be seen in contact lens wearers without any inflammation, lens migration, or other definite cause. Hard contact lens wearers may develop ptosis from levator aponeurosis disinsertion from years of repeated stretching of the lid during lens removal. A second proposed mechanism is that the repeated trauma of the lens edge rubbing against the palpebral conjunctiva produces chronic inflammation and edema in the soft tissues of the lid. Because all or part of the ptosis may resolve with discontinuation of contact lens wear, it is recommended that patients stop wearing their lenses for a period of time prior to surgical correction of the ptosis.

Conjunctival Abnormalities

Contact Allergy

A contact dermatitis hypersensitivity reaction can be produced by one of a host of chemicals, which are found in contact lens solutions. A typical reaction consists of marked itching with varying amounts of injection, burning, redness, tearing, mucoid discharge, and occasionally chemosis. In addition, the lid may become edematous and erythematous. Cold compresses and the elimination of

the offending chemical usually relieves symptoms. A short course of topical steroids can be used in particularly severe instances.

Giant Papillary Conjunctivitis

Approximately 1-3% of contact lens wearers eventually develop a symptom complex of GPC consisting of conjunctival injection, mucous discharge, itching, tear film debris, coated lenses, blurred vision, excess lens movement, and blurred vision. These symptoms may remain minimal or progress to complete lens intolerance.

The symptoms of GPC are exacerbated by anything that increases the contact of the lens deposits with the tarsal conjunctiva (increased numbers of deposits, increased size of the contact lens, and increased wearing time, especially overnight wear).

Contact Lens–Induced Superior Limbic Keratoconjunctivitis

Contact lens–induced superior limbic keratoconjunctivitis (CL-SLK) is an immunologic reaction in the peripheral conjunctiva produced by contact lens wear.

The contact lens is a foreign body, which rubs across and is pressed against the corneal epithelium with each blink, thousands of times each day. This can results in an abrasion. Corneal abrasions from contact lens wear need to be recognized and treated because they indicate chronic epithelial stress due to the contact lens. Epithelial defects can allow bacteria to penetrate the cornea, resulting in a stromal infection. Chronic corneal epithelial trauma can stimulate sub epithelial fibrosis in the absence of an infection.

Manipulation of a contact lens during insertion and removal can traumatize the epithelium creating painful abrasions of a variety of shapes and sizes. Debris trapped under a contact lens or a chip or tear in the edge of a contact lens can produce dramatic curvilinear abrasions..

Punctate epithelial erosions occur commonly with contact lens wear and have several causes. Three staining patterns are characteristic for rigid lenses, as follows: central, peripheral, and 3- and 9-o'clock positions. If a lens is too flat for the particular cornea, it may produce central punctate staining. A steep cornea, such as in keratoconus where the lens rubs on the tip of the cone, is a typical example. A lens that is too steep for the cornea can produce peripheral punctate staining patterns, often in a superior arcuate shape. A poorly moving lens or one with a large optical zone may produce superior arcuate staining.

The most common staining pattern occurs between the lens and the limbus in the interpalpebral fissure (at the 3- and 9-o'clock positions). This epitheliopathy is caused by the contact lens lifting the lid away from the cornea and poor tear stability with subsequent drying of the cornea. This often is exacerbated by an incomplete blink. A small amount of 3- and 9-o'clock staining is benign, but persistent epithelial erosions can lead to dellen formation, neovascularization, Salzmann-type elevated lesions and pseudopterygium formation.

Punctate staining by soft lenses is not as common as with rigid lenses but can occur. Soft lenses that cause excessive desiccation can cause an inferior central or inferior arcuate pattern. Usually, these patients have minor symptoms of mild irritation or slightly decreased vision.

Epithelial splitting is a common finding in asymptomatic soft contact lens wearers. This finding often is overlooked on a routine examination because it usually does not cause severe symptoms and may be covered by the upper lid. Epithelial splits are horizontal, linear, white, faintly staining epithelial defects in the superior cornea, which often are asymptomatic during lens wear and produce mild foreign body sensation after the lens has been removed.

Chemical Epithelial Defects

Various contact lens chemical solutions can produce a range of epithelial defects from marked erosions to less extensive punctate defects. Surfactant cleaning solutions that are left on the lens after cleaning usually cause immediate pain, redness, photophobia, and tearing upon lens insertion.

If hydrogen peroxide is placed on the eye, it can cause intraepithelial and sub epithelial gas bubbles. These bubbles have a dramatic appearance and can cause significant but usually temporary vision loss. The bubbles typically resolve without permanent sequelae within minutes to hours. However, hydrogen peroxide can cause a permanent refractive change by altering the shape of the cornea.

Enzyme cleaner and chemical disinfection solutions can cause more subtle and intermittent punctate epithelial defects. This condition may require careful investigation and systematic elimination of various lens care products to identify and remove the offending agent. .

Hypoxia

Because the oxygen requirements of the cornea are met by direct diffusion of oxygen from the corneal surface, the barrier of the contact lens reduces the amount of available oxygen. Contact lens wear (especially with a closed lid during sleep) can cause acute hypoxia. If mild, hypoxia produces epithelial edema and temporary blurred vision; if severe, it can cause epithelial cell death and desquamation. Patients usually experience discomfort and remove the contact lenses before the acute hypoxia becomes severe. Typically, the conjunctiva is hyperemic and the epithelium has fine punctate defects, producing temporary decreased vision and photophobia.

Chronic hypoxia produces a variety of more subtle effects such as epithelial microcysts. Contact lens users who sleep in their lenses are prone to developing epithelial microcysts. These transparent epithelial inclusions of degenerated epithelium are about 10-15 mm, begin in the deep epithelium, and slowly migrate anteriorly. Upon reaching the surface, they rupture, creating depressions that pool with fluorescein. It takes several weeks for the microcysts to disappear after discontinuation of the contact lenses. Either the mitotic rate is reduced below normal or the microcysts continue to be produced long after the contact lenses are removed.

One of the hallmarks of chronic corneal hypoxia is superficial neovascularization, especially along the superior limbus. Neovascularization of less than 2 mm from the limbus is not visually significant and generally is well tolerated but is a sign of hypoxia and may be a harbinger of more significant problems. Rarely, deep stromal neovascularization can occur.

Chronic hypoxia has been implicated as a cause of the decreased corneal sensitivity that occurs with prolonged contact lens wear and may be partly the reason why some patients have increased comfort with long-term wear and why they often have decreased comfort with a change from polymethyl methacrylate (PMMA) to gas-permeable contact lenses.

The corneal epithelium is thinner in contact lens wearers. This change may be due to chronic hypoxia and decreased mitotic activity. In addition to thinning of the epithelium, extended wear is associated with decreased epithelial shedding, increased cell size, and increased binding of Pseudomonas aeruginosa to the cell surface. All of these effects could reduce the resistance of the cornea to bacterial infection. The thinner epithelium poses less of a barrier to bacterial penetration. The reduced shedding of epithelial cells allows the attached bacteria to remain on the eye for longer periods of time. The increased binding of bacteria, such as *P aeruginosa,* enables greater numbers of bacteria to attach to the epithelial surface.

The physiology of the corneal epithelium also is altered by contact lens wear. The barrier function of the epithelium is reduced and the permeability to fluorescein is doubled after as little as 2 weeks of soft contact lens wear. Similarly, rigid contact lenses can alter the epithelial permeability.

Superficial Immunologic Reactions

A variety of chemicals in contact lens solutions can elicit superficial toxic or immune reactions. The typical response is a fine punctate keratopathy, conjunctival injection, tearing, itching, and occasionally chemosis.

The preservative, thimerosal, which is now rarely used, produced a keratoconjunctivitis in as many as 10% of contact lens wearers who used thimerosal-preserved products. Essentially, it has disappeared from use but other chemicals used as preservatives or disinfectives can produce similar pathology, so recognition of this condition is crucial.

The earliest symptoms are mild and nonspecific (eg, foreign body sensation, conjunctival hyperemia, variable mixed follicular-papillary hypertrophy), which present gradually after weeks or years of uneventful contact lens wear. The superior limbus becomes progressively more hyperemic and a triangle of punctate keratopathy extends downward from involved limbus toward the central cornea. If allowed to proceed, the epitheliopathy may progress to an opaque pannus with microcysts.

A problem associated with the use of chemical disinfection systems and seen with increasing frequency is the development of small, gray, epithelial, granular opacities that resemble the epithelial opacities of Thygeson superficial punctate keratopathy. The round, gray-white granules appear to be on the surface of the epithelium and are scattered randomly across the cornea. They are similar to Thygeson superficial punctate keratopathy, but they tend to be small and stain less intensely with fluorescein. These opacities are associated with symptoms of foreign body sensation, tearing, photophobia, lens intolerance, and conjunctival injection.

Thimerosal and other chemicals used in disinfection systems also can produce subepithelial infiltrates similar to those seen in adenoviral conjunctivitis. Changing to a preservative-free hydrogen peroxide based disinfection system or to gas-permeable lenses allows these deposits and infiltrates to resolve. However, it may take weeks for the pathology to disappear.

Acanthamoeba Keratitis

The protozoan, *Acanthamoeba,* causes a particularly difficult infection to treat. *Acanthamoeba* is found widely in nature and has been isolated from random samples of soil, water, and air. It can gain access to contact lens solutions and contact lenses from any of these sources, but tap water is a common culprit. Tap water should never be used to rinse contact lenses, store contact lenses, or make saline solution because of the risk of *Acanthamoeba* infection.

The symptoms of infection occur more gradually than in bacterial keratitis. It often takes several days or weeks before the symptoms progress to the point that the patient seeks attention. The early signs and symptoms are foreign body sensation, mild blurred vision, and redness. This progresses to pain, conjunctival injection, rough epithelium, and thickened corneal nerves on slit lamp examination. As the infection progresses, the pain becomes severe, out of proportion to the apparent amount of inflammation, and a characteristic central ring infiltrate forms.

Sub-normal Vision Devices

Ptosis Crutch

Ptosis spectacles are equipped with a crutch that is positioned behind and roughly parallel to the upper eyewire. The crutch supports the skin of the upper lid and prevents the lid from drooping closed. Entropian spectacles are equipped with an additional extension behind and roughly parallel to the lower eyewire, which is known as a crutch or gallery. The crutch supports the skin of the lower lid and prevents the lower lashes from turning in on the eye itself.

Absorptive filters

Absorptive lenses are spectacles whose lenses absorb a high percentage of light, thus reducing the amount of light transmitted to the eye. These lenses are worn in bright sunlight for comfort and for protection from light damage.[13] Absorptive lenses are classified by two variables. The first is the tint of the lens itself, and the second the lens transmission. There are certain situations where a large amount of absorption is desirable. At the same time, there are also circumstances where a maximum of light transmission is desirable. Night driving can be particularly hazardous to the patient and others due to the reduced visual acuity in low light conditions that absorptive filters can induce. Since the need for good illumination increases with age, elderly patients are particularly at risk when fitted with absorptive filters. Opticians must be able to discern when absorptive filters are appropriate and make suitable recommendations to their patients.

Flush Fitting Scleral Shell

The flush-fitting scleral shell is used to cover a blind, unsightly eye that has not otherwise deteriorated to a condition that requires enucleation. Phthisis bulbi, (shrinking of the eye) is a common reason for the fitting of a flush-fitting scleral shell.

[13] Dictionary of Eye Terminology, Third Edition

They also provide a smooth surface for the eye lids to close over thereby improving comfort for the patient. Flush fitting shells are very thin compared to regular ocular prostheses and require precise fitting to achieve successful results.

The patient is usually fitted with a clear flush-fitting trial shell made from a direct impression of the eye. Instructions are given to the patient on how to insert and remove the trial lens and a wearing schedule is provided. Normally the wearing schedule is prescribed over a two-week period adding more wearing time with each passing day.

There are occasional eye socket complications that will make the proper fitting of an artificial eye more challenging, which can include difficulty retaining the prosthesis, restricted motion, and "heavy" eyelids. The most important consideration for most patients, is to be able to wear the shell while in public and during normal waking hours. When the shell can be comfortably worn, a white plastic scleral shell of the same shape is manufactured and hand painted to match the details of the companion eye.

This type of shell usually provides an excellent result and improved patient comfort. A carefully crafted scleral shell not only looks like the other eye, it usually moves in a synchronous manner with the other eye. In addition to the improved appearance and increased comfort, the flush fitting scleral shell provides a more natural surface for normal lacrimal tear function.

10.0 A LEGAL PERSPECTIVE

The risk of harm in dispensing eyeglasses has been upheld in the courts. The relevant documentation of College of Opticians of Ontario vs. Sandra Wadden and King Optical Group is attached[14] A summary of the case follows:

In 1997 Ms. Sandra Wadden, employed by King Optical group dispensed eyewear, specifically eyeglasses, without holding an Ontario Opticians licence. The College of Opticians of Ontario charged Ms. Wadden and King Optical with committing a number of offences. After a lengthy trial, the Honourable Mr. Justice W. D. August found in favour of the College of Opticians and issued his decision and reasons.

Justice August stated in his decision, among other things, that, "…The College called three expert witnesses: an optician, an optometrist and an ophthalmologist. Each witness was highly experienced in their respective field and their evidence was not shaken by cross-examination. These witnesses were of the opinion that the entire process of serving Mr. Barker by Ms. Wadden constituted dispensing. I accept and believe the evidence of the three college experts and I find that their evidence is very relevant and reliable"

"…The defendants proposed to define the controlled act of dispensing in terms of the elements that posed a risk of harm. I find that the College's three experts provided sufficient evidence to establish beyond a reasonable doubt a risk of harm in the dispensing of eye glasses to adults."

On January 18, 2001 the Court of Appeal of Ontario reviewed the case and upheld the decision of Justice August and noted, "…The findings of the trial judge were reasonable and sound and supported by evidence. Further, I find no fault with his application of the law. He found that an unauthorized person was performing controlled acts, namely dispensing contrary to s. 27 (2)(a). He accepted that such activity constituted a risk of harm to the public, pursuant to evidence presented. A review of the information from committee hearings and Hansard prior to the enactment of the legislation leads one to the conclusion that the Legislators considered that a risk of harm was implicit in the prohibited acts specified in s.27 with which I agree."

Justice Dyson, speaking for the Court, rejected the appellant's arguments which were as follows:

Grounds of Appeal

> The appellants raised the following issues as grounds of appeal:
>
> i did the Provincial Appeals Court judge and the trial judge err by failing to determine whether the dispensing of eyeglasses to an adult is a health care service;
>
> ii did the Provincial Appeals Court judge and the trial judge err in failing to define the controlled act of dispensing in terms of risk of harm, and in particular, serious risk of physical harm

[14] College of Opticians of Ontario vs Wadden and King Optical Group (Appendix L)

iii did the Provincial Appeals Court judge and the trial judge err in finding that the dispensing of eyeglasses to a person of visual maturity presents a risk of harm

iv did the Provincial Appeals Court judge and the trial judge err in finding that dispensing is part of prescribing ; and

v. did the Provincial Appeals Court judge and the trial judge err in failing to define the controlled act of dispensing within the sprit and intent of the *RHPA?*

In his Reasons, Justice Norman D. Dyson stated among other things that "I agree that one purpose of the RHPA is to limit the health care activities that unlicensed persons are prohibited from performing to those specific activities associated with a risk of harm. In my view, however, a primary purpose the RHPA is to protect the public from risk. Section 27 (2) does not delegate identification of the level of risk to be protected to the court. Rather the Legislature signalled its intent as to the level of risk to be protected by listing the prohibited activities that constitute controlled acts."

Further he dismissed the appeal.

11.0 WHAT ASPECTS OF DISPENSING EYEWEAR SHOULD BE A CONTROLLED ACT UNDER THE RHPA?

The Risk of Harm sections in this submission have identified and detailed many of the risks of harm inherent in the dispensing of all forms of eyewear. Each specific type of optical appliance carries with it the potential for injury and ample evidence has unequivocally proven that all aspects of dispensing present a risk of harm; both to the patients themselves and to the general population. The risk of harm in dispensing has been reviewed and analyzed over the years in a number of jurisdictions by countless advisory committees and organizations. After each comprehensive review, commissioned study, research project and patient-based survey, no evidence has been found to indicate that not regulating any aspects of dispensing would be of any benefit to the public. During the HPLR, over75 professions sought regulation, however, only 23 were accepted; Opticianry was one of those professions. Since that time, the courts have upheld this decision by confirming that all the components in the continuum of dispensing pose a risk of harm.

The public is not sufficiently protected from the risks of harm in dispensing unless the RHPA continues to contain adequate controls to mitigate the potential risks. This can only be achieved, with respect to the dispensing of eyewear if all aspects of dispensing remain a controlled act.

12.0 HOW SHOULD STANDARDS BE SET AND MEASURED FOR DISPENSING EYEWEAR?

Section 3 of Schedule 2, the Health Professions Procedural Code sets out the "Objects of the College". The third object of all the Ontario Health Professional Colleges, as prescribed in the legislation, is as follows:

> *"To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession"*

It is clear from the legislation that Health Regulatory Colleges are identified as the sole body with the authority to set and measure Standards of Practice for their members. Additionally, HPRAC in its advice to the Minister of Health and Long-Term Care on September 27, 2000, stated, "… that health profession regulatory colleges do have the *authority and the responsibility* to develop, establish and maintain guidelines and standards of practice for its members governing public domain activities that are outside the profession's legislated scope of practice". The Colleges are responsible to develop Standards of Practice for activities outside the scope of practice of their members, there is an even greater responsibility for the Colleges to set and maintain Standards of Practice for activities within a profession's scope of practice.

The COO currently has a process for the development and setting all Policies including Standards of Practice. Once a policy issue has been identified, the initial development of it is assigned to the appropriate Committee and administrative staff. When the policy issue involves either the development of new Standards of Practice or the amendment of existing Standards of Practice the COO embarks on a policy development process. A key component to this part of the process is to consider the views of a variety of stakeholders to determine what is being done in other similar professions or other jurisdictions.

When the proposed Standard of Practice is developed it is presented to Council for approval in principle. This means that the Council has approved the general direction of the proposed Standard of Practice but that it is not yet an expectation of profession. Following approval in principle, the COO undertakes a formal consultation with College stakeholders for their views on the change. While there is no statutory obligation on the College to consult with registrants on proposed changes to its Standards of Practice, the College believes that it is beneficial to obtain feedback on proposed standards prior to their formal implementation.

All comments and submissions are reviewed using a thematic process of analysis. A report on the general themes is written, and issues raised that suggest needed revision are identified for Council deliberation. The Standard of Practice is presented to Council for final review and or approval. This process includes Council consideration of the original proposal; the analysis of the feedback provided by stakeholders; the proposed changes that were suggested by the consultation phase or by other considerations; and any proposed final position(s). The standards are enacted and enforceable upon Council approval.

The Regulatory Colleges are capable of measuring the Standards of Practice for the profession that they govern. The RHPA allows for both internal and external mechanisms to ensure that Standards of Practice are being met by the membership.

The Quality Assurance (QA) Program of the COO is one mechanism to measure the efficacy of COO's Standards of Practice. The RHPA defines QA as "a program to assure the quality of practice of the profession and to promote the continuing competence among members". All college members are required to participate in the QA programs and cooperate with the QA assessors appointed. Failure to participate in a College mandated QA program could lead to a suspension of membership.

In addition to the mandatory participation in QA programs that include the peer assessor program, Opticians self-identify their continuing education needs by choosing which continuing education activities they will attend and participate in. A relevant example would be the post-graduate refraction program offered recently by Georgian College for the first time. The requests from Opticians to participate in this course, despite the fact that Opticians at present are not permitted to perform refractometry, was so great that Georgian College increased its intake by offering a second course to meet the demand.

The COO would like to note for the record that the compliance rate for Opticians has hovered around 98% over the years that QA has been a mandatory requirement. This number is remarkable in and of itself, but is even more significant when one considers that all Opticians must submit proof of compliance with the QA program; the College does not accept a random sampling of the membership.

The Complaints and Discipline processes prescribed in the RHPA provide another mechanism for the measurement of the Standards of Practice of a profession.

Not only does the complaints process screen for potential trends by the membership to fail to meet standards set, the decisions of the Complaints Committee are open for review by the Health Professions Review and Appeal Board (HPARB). This outside, arms-length review of Complaints Committee decisions, ensures that the Complaints Committee is making decisions that are fair, reasonable and in the public interest. If a member of the profession failed to meet any of the Standards of Practice of the profession and the Complaints Committee failed to take action, HPARB would, upon review of that complaint, require the Committee to reconsider its decision and take appropriate action.

A Discipline Panel of any Health Regulatory College may receive from either the Complaints or Executive Committee a referral for a breach of the Standards of Practice. Subsection 51(2) of the Code provides several orders that a panel of the Discipline Committee may make upon finding a member has breached a Standard of Practice. Those orders include: revocation; suspension; or imposition of specified terms on a certificate of registration.

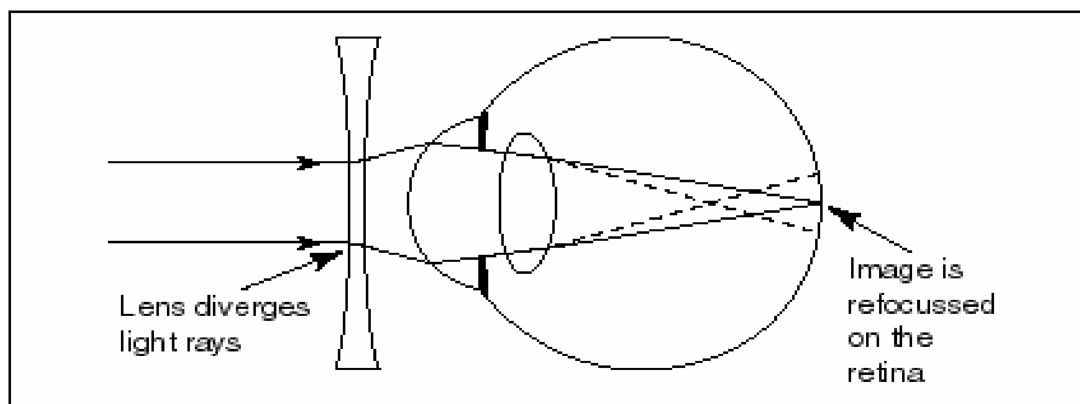
Taking into consideration that the RHPA grants colleges the statutory authority to set standards of practice, provides mechanisms for measurement and that the COO has the procedures in place to meet those responsibilities, standards of practice should continue to be set and measured within the existing framework.

13.0 REFRACTOMETRY

Refractometry, also known as refracting, refraction or sight testing is the process of measurement that assesses how the eye is bending and focusing an image on the retina of an eye. A person with normal vision focuses an image in a precise point – the focal point – exactly on the retina. For nearsighted individuals, the image comes to a point in front of the retina, making close objects appear clearly, but rendering objects further away more difficult to see. In farsighted individuals, the image is focused behind the retina making them able to see distant objects, but less able to see objects that are near.

Generally, the primary reason why individuals' vision varies is the shape of the eyeball. In near-sighted individuals, the eyeball tends to be longer than a normal vision eyeball; in far-sighted individuals, the eyeball tends to be shorter than a normal vision eyeball. Furthermore, the structure of the eyeball can change over time due to ageing and other factors.

Refractometry measures the angles and distance from the retina where the focal point falls. Various powers of concave or convex lenses are placed in front of the eye to modify the angles at which light is bent and to adjust the focal point so that it falls exactly on the retina. In this way, the strength of the corrective lens is determined to best enable the individual to focus an image most clearly in a precise point on the retina. Each individual's eye has a specific mathematically determinable calculation that defines its visual capabilities (see figure below). A refractive measurement spells out that calculation and the requirements to improve the visual acuity.



Refractometry is not a medical procedure, but rather is a process of precise measurement of visual acuity. According to the Canadian Ophthalmological Society, "a diagnostic eye examination involves the practice of medicine and requires the highly specialized training of a physician. A refractive examination involves the taking of measurements from the visual system, which is simply a data-gathering procedure and involves no medical expertise." [15]

Prior to the COO ban on refractometry, in a typical situation the Optician would have had a relationship with a physician or optometrist and the Optician would send the results of the refraction to the Physician or Optometrist to have them either prescribe or approve a visual correction; or in

[15] Canadian Ophthalmological Society's policy statement – Role of Ophthalmology (Appendix M)

some instances, the Optician might recommend that the patient be re-examined. This practice was both convenient and cost effective for the patient and ensured that the vision devices dispensed by the Optician met their patients' needs and expectations. Requiring citizens to have a full ocular visual assessment when all they need or desire is a refractive examination serves only the economic interest of Optometrists at the expense of the public.

14.0 HISTORY OF REFRACTOMETRY

During the College of Opticians presentation to HPRAC on April 21, 2005, the Council requested a full history of events around Opticians refracting. The following is a summary of events and correspondence.

At the July 17, 1998 meeting of the Council of the COO, the Council passed a motion acknowledging that "Sight-Testing is not part of any controlled act". The motion carried with 10 Council members in favour, one abstention and one Council member absent from the vote. At the December 11, 1998 meeting of the Council of the COO, the Council passed a motion that resolved "refractometry is an integral part of the scope of practice of Opticianry, as defined in the *Opticianry Act*". The resolution was passed with ten Council members in favour and two Council members absent from the vote.

The COO met with the College of Optometrists, the College of Physicians and Surgeons and Ministry officials on November 22, 1999 to discuss refractometry. That same month, the COO sent the Ministry of Health its "Refractometry Position Paper"[16] attached as Appendix N. On December 30, 1999 the COO received a letter from the Ministry of Health and Long-Term Care directing the Council of the COO to reconsider its policy that refracting is within the scope of practice of Opticians.[17]

The November 1999 position paper was followed up in February 2000 with a submission entitled "Report of the College of Opticians of Ontario to the Minister of Health and Long-Term Care, Advice on the Performance of Refractometry by Opticians in Ontario".[18]

The COO attempted to schedule meetings with the College of Optometrists and the College of Physicians and Surgeons to discuss refractometry. On February 1, 2000 the COO received a letter from the CPSO stating "Our College has determined that it does not wish to become involved in this stage of the discussions on this issue".[19] During the same timeframe the College of Optometrists indicated in a letter to the COO, dated February 7, 2000 that they would not meet with the COO to discuss refractometry unless the COO directed its members to cease and desist performing refractometry.[20]

On May 9, 2000 Elizabeth Witmer the Minister of Health and Long-Term Care at the time sent a letter of referral to HPRAC. The referral contained the following six questions:

1. Is testing for refractive error of the eye included in the scope of practice of opticianry as stated in the *Opticianry Act, 1991*?

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[16] COO Refractometry Position Paper, November 1999 (Appendix N)

[17] December 30, 1999 correspondence from the Ministry of Health & Long-Term Care (Appendix O)

[18] February 2000 Report of the College of Opticians of Ontario to the Minister of Health and Long-Term Care, Advice on the Performance of Refractometry by Opticians in Ontario (Appendix P)

[19] February 1, 2000 correspondence from the College of Physicians & Surgeons of Ontario (Appendix Q)

[20] February 7, 2000 correspondence from the College of Optometrists (Appendix R)

2. Can a College regulate the practice and conduct of its members in provision of services to the public if the activities performed are not controlled acts under the RHPA and are outside of its statutory scope of practice?
3. Do colleges have the authority to develop establish and maintain guidelines and standards of practice for its members governing public domain activities that are outside of the professions scope of practice?
4. If colleges have the authority to develop establish and maintain guidelines and standards of practice for its members governing public domain activities that are outside of the profession's legislated scope of practice can a college enforce these guidelines and standards of practice through such mechanisms as complaints and discipline, and registration requirements?
5. Do scope of practice statements determine the boundaries of the activities or the regulatory colleges?
6. If a College has the authority to regulate and impose standards of practice on its members for activities outside its legislated scope of practice, would a college doing so have an impact on that profession's legislated scope of practice for the purposes of the administration of the RHPA?

HPRAC sent its advice to Minister Witmer regarding these questions on September 27, 2000. On February 7, 2001 Minister Witmer sent the COO a letter requesting that the Council of the COO "…immediately inform the members refractometry is not part of the scope of practice under the *Opticianry Act, 1991* and requesting "…that the College immediately take appropriate steps to prohibit the performance of refractometry and the altering of a prescription by its members."[21] The COO complied with both these requests at its March 9, 2001 Council meeting and subsequently issued a College bulletin to the Membership stating that the Council had adopted a standard of practice stating that Opticians shall not perfom refractometry, nor shall they use the results of a refractometry test to alter a prescription.[22]

During the period from May 2001 to August 2001 the COO attempted to arrange joint meetings among the three colleges, to engage in the consultation process requested by the Ministry. Both the CPSO and Optometry declined to meet with the COO, but rather offered to comment on any draft standard developed by the COO.[23]

On November 5, 2001 the Hon. Tony Clement, Minister of Health and Long-Term Care at the time, wrote to the three Colleges (Opticinary, Optometry and Physicians and Surgeons) giving the Colleges 60 days to produce a single status update regarding how they would proceed to resolve refractometry.[24]

Following this directive from the Ministry, a number of meetings took place between the COO, the College of Optometrists and the College of Physicians and Surgeons to discuss refractometry: November 19,2001, January 23,2002 (conference call), May 27, 2002 (this meeting was facilitated by a Ministry of Health and Long-Term Care appointed mediator) and May 24, 2004.

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[21] February 7, 2001 correspondence from Minister Witmer (Appendix S)

[22] College of Opticians of Ontario Membership Bulletin (Appendix T)

[23] Series of correspondence (Appendix U)

[24] November 5, 2001 correspondence from the Hon. Tony Clement (Appendix V)

As a result of a number of communications, it was agreed that the COO would develop a draft standard of practice to be circulated to the College of Optometrists and the College of Physicians and Surgeons for comment. The CPSO and the College of Optometrists had previously stated that the only standard of practice they would accept would be one that involved in-office supervision. This was unacceptable to the COO as the Council believed that Opticians should be able to perform refractions independent of an Optometrist or a Physician. In an effort to compromise, the College developed and approved in principle Standards of Practice allowing Opticians to perform refractometry without in-office supervision but upon instruction by the patient's prescriber (Optometrist or Physician). That Standard of Practice would have allowed Opticians to refract, but prohibited Opticians from applying the results of any refraction in their dispensing activities without a prescription from a Physician or an Optometrist. The COO was hopeful that this modified standard bridged the gap between the differing perspectives. The College of Optometrists and the College of Physicians and Surgeons both found this modified standard unacceptable (see Appendix W).

On May 15, 2003 despite not having reached a consensus with the other colleges, but in an effort to move forward with the now more than two year old ban, the COO provided the Minster of Health and Long Term Care, Hon. Tony Clement with the Council approved Standards of Practice for Refraction. In the cover letter the COO detailed its intention to lift the ban as all avenues for collaboration had been exhausted. The letter stated "In addition, at some 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 and adjust prescriptions to reflect the results of refractions, pursuant to standards of practice promulgated by this College."[25]

On June 3, 2003 a document entitled "Public Interest Rationale for the Standards of Practice for Refractometry by the College of Opticians of Ontario" was circulated to both the College of Optometrists and the College of Physicians and Surgeons of Ontario as well as the Ministry of Health and Long Term Care. [26]

On June 24, 2003 the COO received a letter from Marilyn Wang, Director, Ministry of Health and Long Term Care stating among other things "…it will be at the Minister's discretion as to when it is appropriate to remove the prohibition on the performance of refractometry by members of your College."[27] As a result of that letter the Council opted not to lift the ban on refraction at that time but to continue working with the MOHLTC towards a resolution acceptable to both the Ministry and the COO.

In August 2003 the COO wrote to the College of Optometrists, the College of Physicians and Surgeons and the Ministry of Health and Long Term Care to address their concerns with the proposed Standard of Practice for refraction.[28]

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[25] Standards of Practice with cover letter to MOHLTC from COO and comments from the CPSO and Optometry (Appendix W)

[26] Public Interest Rationale document (Appendix X)

[27] June 24, 2003 correspondence from Marilyn Wang, MOHLTC (Appendix Y)

[28] Response to comments on Draft COO Standards of Practice (Appendix Z)

On September 30, 2003 the COO received a letter from Allison Henry, Acting Manager at the Ministry thanking the COO for its response. She provided assurances that the Ministry would only be dealing with urgent matters until the provincial election process had concluded.[29]

In 2004 the three Colleges met once and the COO had several meetings with the Ministry. The British Columbia refracting model was discussed during the meeting of the three colleges. The College of Physicians and Surgeons suggested the group explore further the options this model presented. The College of Optometrists maintained in-office supervision was the only standard they would accept.

At the November 2004 Council meeting the Council of the COO discussed the possibility of requesting a referral to HPRAC requesting a change in the written scope of practice for Opticianry to include refraction. At that meeting Council, via a motion, unanimously approved, in principle, the request for an HPRAC referral for the purposes of refraction and a change in the scope of practice for Opticianry.[30]

On February 7, 2005 the Registrar and President met with Ministry officials to discuss refractometry, including the possibility of the COO requesting a referral to HPRAC with respect to refractometry. A Ministry official stated that since HPRAC had already reviewed this issue once, the COO would have to present a "compelling reason to go there again". That same day the Minister of Health and Long-Term Care sent his referral letter to HPRAC requesting that HPRAC advise whether refractometry is in the scope of practice of Opticians.

[29] September 30, 2003 correspondence from Alison Henry, Acting Director, MOH (Appendix AA)

[30] Motion from November 2004 College of Opticians of Ontario Council Meeting (Appendix BB)

15.0 IS THERE A RISK OF HARM IN PERFORMING REFRACTOMETRY?

Refractometry is not a controlled act under section 27 of the *Regulated Health Professions Act.* It is therefore, a public domain act and can be performed by anyone. Accordingly, in many Optometrists' and Physicians' offices throughout Ontario (and North America for that matter) office assistants and other unregulated staff routinely perform refractometry.

The reason that dispensing of optical devices is a controlled act is the same reason that prescribing of optical devices is a controlled act: it poses a risk of harm to the public. Only registered members of health Colleges whose members are authorized to perform the controlled act have sufficient training and experience to protect the public against the risk of harm.

What is the risk of harm that prescribing and dispensing of optical devices poses to the public? Broadly speaking, if a patient's visual error is not properly corrected, the patient will be at risk to himself in his own environment, and may cause harm to others. The harm that may befall the patient if an incorrect prescription is given is the same as the harm that will occur if the prescription is incorrectly dispensed.

An Optometrist or Physician who sees a patient will, generally, not only measure the patient's refractive error and, if necessary, prescribe corrective lenses, but will also perform an examination of the patient's eyes with a view to determining if the patient has any underlying eye conditions or diseases. Opticians are neither trained nor qualified to perform such an eye examination and have never sought the right to perform such an examination. However, a refraction and an eye examination are not intrinsically linked, and a refraction by itself is not a medical procedure. The Canadian Ophthalmological Society states, "a refractive examination involves the taking of measurements from the visual system, which is simply a data-gathering procedure and involves no medical expertise"[31]. In *College of Opticians of British Columbia* v. *Moss et al.*[32], the British Columbia Supreme Court rejected the argument that the operators of automated sight testing equipment were conducting eye examinations. The British Columbia Ministry of Health Services is on record as saying:

> "Eye health exams assess the medical health of a patient's eyes, as well as their vision, and can only be performed by an optometrist or ophthalmologist. Sight tests only measure the refractive error of the person's eyes to indicate the power of the lens needed to correct their vision."[33]

It is not necessary each time a patient[34] needs new corrective lenses, for the patient to have a complete eye examination. The fact that regular eye examinations have now been delisted from OHIP for patients between the ages of 19 and 65 who do not have eye disease or other conditions of the eye indicates the government's view that periodic eye examinations are not medically necessary.

[31] see Appendix M

[32] College of British Columbia v Moss et al (Appendix CC)

[33] Ministry of Health Services (B.C.) News Release, March 30, 2004, "More Choices for Eye Health Care Announced".(Appendix DD)

[34] It is recognized that patients with certain eye diseases such as glaucoma, as well as children and seniors, may require more intensive involvement of a physician or optometrist and accordingly the College of Opticians does not propose to allow its members to dispense to persons in those categories without prescriber involvement.

Patients who visit an Optician because they want to update their eyewear or replace lost or damaged glasses may wish to have their refractive error measured to ensure that their current prescription is still valid. There is no valid reason why they must be subjected to a complete eye examination in order to do so.

On the other hand, there is a risk of harm to patients from the dispensing of corrective eyewear and therefore it is vital that the measurement of the refractive error be done safely and accurately. The College is of the view that only regulated health professionals such as Opticians who are trained to do this should be permitted to dispense based on the results of refractive measurement, and only subject to strict conditions that will protect the public. The College is of the view that its members, with sufficient training and experience, and subject to strict regulation by the College, can safely and accurately administer refractive examinations to patients and dispense on the results of the tests without prescriber involvement, and is in the public interest that they do so.

Measurement of refractive error has evolved through automation to the point where, with proper training, it can be done accurately and safely. Automated sight tests have been scientifically proven to be safe, reliable and reproducible tests.[35] The test is performed using equipment and a sophisticated computer program to test and measure visual acuity, and the strength of the lenses that is needed. Moreover, a pair of eyeglasses that is dispensed in accordance with the results of the refraction will in most cases satisfactorily correct a patient's measured visual error.

Optometry groups believe they must fundamentally link prescribing ophthalmic appliances with a full ocular examination. While some patients may indeed choose such a course of action, it is paternalistic to mandate that all patients must undergo such an examination every time they wish to order eyewear. This can be compared with a requirement that all patients must undergo a full physical examination on each visit to a Physician. It is simply not necessary.

In order to protect the public, the College will require that refractive examinations be given only to consenting adults who are in good health and who have been fully informed that the test measures only visual acuity and is not a complete eye health examination. Specific illnesses, symptoms and procedures will also make individuals ineligible for refractions a full ocular visual assessment, unless they are already under a Physician's supervision for their condition and the Physician approves the optician doing the refraction. Opticians will not be able to dispense without a prescription to persons who cannot achieve a defined level of visual acuity, or whose visual acuity has declined by a specific amount within a set period. The College will apply strict Standards of Practice including a mandatory requirement that refractions may only be performed on patients who have had a full eye examination within a certain maximum period, prior to the refraction. Members will be required to undergo mandatory training before they are permitted to engage in refractometry, and will be encouraged to participate in refraction-specific continuing education in order to ensure ongoing competence. Final screening protocols have not been developed and approved by the COO at this time. However, there are some templates that were developed for and in use in other jurisdictions.[36] The COO would utilize these existing templates to assist in the development of screening protocols that would protect the public of Ontario while meeting their needs.

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[35] Report from Dr. Dyer M.B Ch. B., F.R.C.S. (C); Angus H. Kirk M.D., M.S.c, F.R.C.S (C) (Appendix EE)

[36] Draft templates (Appendix FF)

It is important to emphasize that the College is not seeking to give Opticians the power to prescribe. Opticians will be augmenting existing lens powers to fine-tune visual acuity within a specified age group and power, and in accordance with appropriate Standards of Practice.

16.0 IS REFRACTOMETRY WITHIN THE SCOPE OF PRACTICE OF OPTICIANS?

The position of the COO in its 1999 Refractometry Position Paper, its February 2000 submission entitled "Report of the College of Opticians of Ontario to the Minister of Health and Long-Term Care, Advice on the Performance of Refractometry by Opticians in Ontario" and its July 31, 2000 submission to HPRAC[37] was that refractometry is included in a broad interpretation of Opticianry's scope of practice as an integral part of the provision, fitting and adjusting of optical appliances.

One can view the term "scope of practice" as a description of what Opticians actually do, as opposed to the scope of practice statement in the *Opticianry Act.* In that context then refraction is within the scope of practice since Opticians are currently performing refractometry in Alberta and British Columbia and, prior to the ban being imposed, were performing it within Ontario.

In its advice to the Minister of Health and Long-Term Care, HPRAC concluded that the testing for refractive error of the eye was not within the scope of practice of Opticianry as stated in the *Opticianry Act*, i.e. it was not covered by the specific scope of practice language in the Act.

Minister Witmer wrote to the COO on February 7, 2001[38] and stated in her letter "…I request that the College Council immediately inform the members that refractometry is not part of the scope of practice under the *Opticianry Act, 1991.*" The COO held a Council meeting on March 9, 2001. After receiving presentations from a number of stakeholders and receiving information from a Ministry official present at the meeting, the Council reversed its earlier position and passed a motion accepting the Ministry position that refraction is not within the scope of practice of Opticians.

HPRAC did not recommend that Opticians be prohibited from engaging in refractometry. HPRAC acknowledged that whether or not to prohibit members from acting outside the scope of practice of their profession was a choice for Colleges to make and was not mandatory. Therefore, in requesting that the College prohibit the performance of refractometry by its members, the Minister went beyond HPRAC's recommendations. The Minister said that her request was based on HPRAC having expressed a concern that the performance of refractometry by Opticians could circumvent the public safety measures within the RHPA. However, what HPRAC expressed a concern about was not the performance of refractometry by Opticians, but their using the measurements from a refraction test in order to generate or change a person's prescription.

[37] Documents and correspondence (Appendix GG)

[38] See Appendix S

17.0 SHOULD REFRACTOMETRY BE WITHIN THE SCOPE OF PRACTICE OF OPTICIANS?

In its 2000 advice to the Minister, HPRAC explicitly stated "Given the very specific nature of the questions in the attached referral letter, HPRAC provides only the interpretation of Acts in response to the questions. HPRAC does not comment on the public interest issues associated with opticians testing for refractive error of the eye because HPRAC believes that these issues would be better addressed as a part of a review of a request for expansion of scope of practice." Thus, there has been no finding that refractometry by Opticians is against the public interest.

The current referral to HPRAC asks the same question: namely whether refractometry is within the scope of practice of Opticians. The COO interprets this question to mean should refractometry be within the scope of practice of Opticians.

The COO's only objective is to serve and protect the public interest in Ontario. To do so this College is recommending changes to the *Opticianry Act, 1991* in order to allow Opticians to perform refractometry and further, to allow them to apply the results by adapting prescriptions, within limitations defined by the COO. Not only do we believe that there is a compelling public interest case for doing so, we also do not believe that there is a single, compelling public interest argument against it.

Currently in Ontario, Registered Opticians are taught the core elements of refractometry in existing educational programs. In addition, there are also courses in place, approved by the College of Opticians of Ontario, should the Optician wish to sight test and dispense based on the results, once the ban is lifted. The ban has prevented trained Opticians from performing a task that is performed daily by non-registered, less qualified persons. Only Registered Opticians have been prohibited from performing a procedure that any other member of the public can perform. It is nonsensical that Opticians who are trained to perform refraction should be prohibited from performing a public-domain procedure that can be and is legally performed by unregulated and untrained individuals.

The College assumes full responsibility for the enforcement mechanisms set out in the legislative framework of the RHPA. The College has historically engaged both the complaints and discipline processes as a component of regulating its Members. The overwhelming proportion of complaints that the College of Opticians of Ontario has received to date regarding refractometry, have been from optometrists, as opposed to patients.

The COO believes the ban against Opticians refracting is discriminatory and contrary to the public interest when viewed in context with similar health care models in Ontario. For example, like refractometry, the prescription and dispensing of orthotics is a public domain act. It is referred to specifically in only the scope of practice statement of Chiropody/Podiatry. Nevertheless, several professions and particularly Chiropractic, Physiotherapy, Massage Therapy and medicine prescribe and dispense orthotics in considerable volumes. The government has never directed or even suggested that a ban be imposed on those professions whose statutory scope of practice has no reference to orthotics, pending development of a Standard of Practice with other colleges. This, despite the fact that the prescription and dispensing of orthotics has attracted considerable attention

because of increasing incidence of fraud. The ban on refracting is inconsistent with the government's position on the prescribing and dispensing of orthotics.

The public interest case consists of the following elements:

Public Protection

The COO is prepared to draft a Standard of Practice that will protect Opticians' patients by ensuring that patients in "at risk" categories, or patients who display any contraindications, are referred to their Physicians or Optometrists for full ocular visual assessments and prescriptions. Opticians are fully trained to recognize pathology that presents a significant contraindication to moving forward with patient care, and to refer patients to the appropriate healthcare professional. This is done by Opticians in their practice every day.

The COO is cognizant of the fact that the public may be confused about the difference between a full oculo-visual assessment and a measurement of refractive error. The Client Awareness form will ensure that Opticians' patients are fully apprised of the limitations of a sight test and that patients will be able to make an informed choice whether to accept the results of this test or obtain a full ocular-visual assessment.[39]

Enhanced Access

The proposed amendments included in this document will enhance the public's access to necessary healthcare. Rather than requiring a Physician or Optometrist's examination in each case, which is both expensive and time-consuming, patients can have Opticians make the necessary, minor adaptations. Patients should have the right to make an informed choice between having their Opticians adapt their prescriptions in an appropriate case, or be referred to their Physicians or Optometrists for a full oculo-visual assessment.

Such practice is equivalent to a patient who has suffered a broken arm. The patient will make an appointment with a Physician to have the arm set. However, the Physician will not normally on each visit give a full physical examination on the patient. If the Physician were required to perform a full physical examination for this particular patient, as well as every other patient that comes into his office, the time and cost to the healthcare system would be unimaginable. The same argument can be used for a full oculo-visual assessment when only the measurement of refractive error is necessary.

Furthermore, the legislative amendments this College proposes are consistent with the Minister's Duty under Section 3 of the *Regulated Health Professions Act, 1991*, namely,

> *"…to ensure that … individuals have access to services provided by the health professions of their choice…"*

Liberalizing access to vision care will become even more important in light of the de-listing of eye exams from OHIP for certain patient groups. Given that most individuals will now have to pay out-

[39] Client Awareness Form (appendix HH)

of-pocket for a full eye-examination, many individuals may choose to forgo examinations due to the expense. It is our belief that the process of more widely available sight testing will provide an important screening function that may alert many individuals to underlying eye or vision abnormalities requiring full ocular-visual exams by a Physician or an Optometrist. If Optometrists continue to refuse to separate a test for refractive error from a full oculo-visual assessment, the costs to the consumer will continue to be artificially inflated and the wait times to see an Optometrist can only increase.

The American Academy of Ophthalmology guidelines for frequency of an eye examination are as follows.[40] These guidelines have been endorsed by the Canadian Ophthalmological Society:

Recommended Frequency of an Eye Examination

- Adults between the ages of 20-29 should have an eye health examination once during that period.
- Between 30-39 individuals should have two eye health examinations.
- Between the ages of 40 and 64 an eye health examination is recommended every 2 to 4 years.

The American Academy of Ophthalmology believes that yearly eye health examinations for individuals who are not at risk unnecessarily escalate the cost of vision care.

Many individuals, particularly in rural and remote areas, do not have access to a Physician or Optometrist. If an individual does have a Physician or Optometrist, the wait time to have an appointment for an eye examination can be lengthy.

According to the Canadian National Institute for the Blind "Currently there are not enough Opthalmologists to meet the needs of Canadians, and residency programs in Opthalmology are graduating fewer specialists that at the beginning of the 90's, while the profession is aging and starting to retire or curtail its activities. This apparent imprudence in public health policy could have disastrous consequences in the next 25 years, and must be addressed.[41]

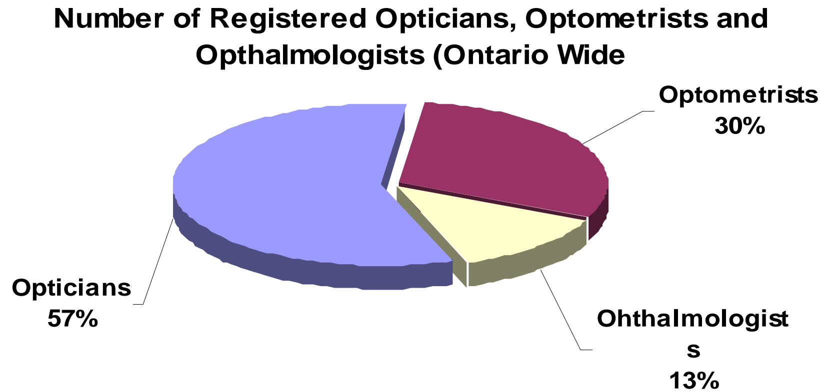
Most communities in Ontario have at least one Optician who is easily accessible and in most cases an appointment is not necessary to see them, nor are there lengthy waiting lists. Utilizing the services of an Optician would result in an appropriate referral to other eye specialists where potential vision problems have been identified in citizens who might otherwise go unidentified.

Alleviating Ophthalmologists or Optometrists of the need to examine each of their patients before allowing Opticians to make minor adaptations to their prescriptions will increase the ability of the ophthalmologist to deal with instances where the health of the patient actually requires a full eye-examination or require more invasive procedures.

[40] American Opthalmological Society guidelines for frequency of eye examinations (Appendix II)

[41] CNIB submission to the Commission on the Future of Health Care in Canada December 2001 (Appendix JJ)

HUMAN RESOURCES STATISTICS



Enhanced Competition

There is documented and anecdotal evidence suggesting that barriers to competition among healthcare providers adds substantially to healthcare costs. Basic economics demonstrates that competition will bring down costs relating to vision care for healthcare consumers and third-party payers. The public is not well served if any profession has a monopoly on the manufacturing, wholesaling, dispensing, prescribing, diagnosis and treating in the vision care sector.

18.0 REQUIRED LEGISLATIVE CHANGES

To change the scope of practice of Opticians to include refractometry the following amendments would be required:

Section 3 of the Opticianry Act (the "Act") would be amended to read as follows:

> 3. The practice of opticianry is the provision, fitting and adjustment of subnormal vision devices, contact lenses or eyeglasses, and the measurement of refractive error.

This legislated increase in the scope of practice would be necessary in order to give the College the clear legal authority to regulate and establish standards of practice in the area.

Subsection 5(1) of the Act would be amended to read as follows:

> 5. (1) A member shall not dispense subnormal vision devices, contact lenses or eyeglasses under the authority of section 4 except upon the prescription of an optometrist or physician or as permitted by subsection (1.1).

A new subsection 5(1.1) would be added to the Act as follows:

> 5. (1.1) A member may dispense subnormal vision devices, contact lenses or eye glasses under the authority of section 4 without a prescription of an optometrist or physician, based on the results of a measurement of refractive error, where the member has conducted the measurement of refractive error and has complied with the Schedule of requirements set out in the Regulations.

The Schedule would set out all the College's requirements, relating to such matters as: age and health restrictions; required notice to the patient; etc. It should be noted that s. 5(1.1) contemplates **only members** doing the refractions- i.e. not their staff. The rationale for this is that it ensures that only trained and qualified opticians are doing the refracting and then the dispensing, and it ensures compliance with the Schedule, which places obligations directly on the Optician.

Amendments to College Regulations

The COO's regulations will have to be amended to reflect the fact that members will be refracting and dispensing on the results of the refraction. The College will make any and all necessary changes to regulations, bylaws, standards and policies to reflect the suggested changes in the legislation. Such things as entry to practice competencies, curriculum requirements and examinations will be developed in accordance with the changes. The College is prepared to work with the Ministry of Health and Long-Term Care to enact regulations setting out entry to practice and quality assurance requirements.

19.0 OTHER JURISDICTIONS

Opticians are regulated in every province in Canada, with numbers totalling approximately 6 000. In each case, Opticians are granted the authority to perform dispensing functions according to their provincial health legislation which includes provisions for title protection, reserved or controlled acts and scope of practice statements.[42]

Canadian Opticians have been providing refracting services using various models of automated devices since 1998 in British Columbia, Alberta and in Ontario.

The discussion of whether to include refractometry (i.e. sight testing) in the scope of practice for Opticians is currently taking place in other jurisdictions throughout Canada.

In British Columbia the government has endorsed amendments to the *Opticians Regulation* that would enable Opticians in B.C. to perform sight testing on British Columbians between the ages of 19 and 65 without the involvement of a physician or optometrist.[43] The regulation will also allow opticians to dispense corrective lenses based on the results.

Similarly, Opticians' regulatory organizations in Alberta, Saskatchewan, and Manitoba are seeking similar changes to legislation for expanding the scope of practice for Opticians to enable them to refract. After a complete review of the eyecare delivery system in Alberta the government has reaffirmed the practice of the telehealth model of sight testing that has been used by Alberta Opticians since 1996. [44]

The College of Physicians and Surgeons of Alberta (CPSA) have been most supportive of legislative change in Alberta to allow Opticians to perform refractometry, as evidenced by the letter from Dr. Bryan Ward Assistant Registrar of the CPSA to Ms. Georgann Wilkin, Director of Health Profession with Alberta Health and Wellness.[45] The letter clearly states that their "…Council's legislative committee is satisfied that the public interest will not be jeopardized by the expanded scope of practice requested by opticians".

Alberta Opticians have been performing refractometry for over seven years. There are over fifty refractometry systems in use in that province alone and thousands of refractometry procedures performed throughout Canada. Manufacturers of Eyelogic Systems claim that there are over 7,000 refractometry tests being performed each month by over 240 trained users of the equipment resulting in over 700,000 tests performed to date. It is noteworthy that in the provinces of Alberta and British Columbia where most of the refractometry procedures in Canada have been performed, there have been no complaints from the public regarding this procedure, to the Opticians regulatory bodies in those provinces.

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[42] Jurisdictional Review (Appendix KK)

[43] British Columbia information (Appendix LL)

[44] Alberta submission (Appendix MM)

[45] Letter from Dr. Bryan Ward Assistant Registrar of the CPSA to Ms. Georgann Wilkin, Director of Health Profession with Alberta Health and Wellness (Appendix NN)

Internationally, jurisdictions such as the United States (i.e. Alaska, Florida, and Washington State), as well as New Zealand have also been considering the change.

20.0 HOW SHOULD STANDARDS BE SET AND MEASURED FOR REFRACTOMETRY?

The responsibility for and the process to set and measure Standards of Practice for refractometry should be the same as outlined earlier for the dispensing of eyewear.

Standards of Practice around specific issues relating to refractometry such as equipment required and patient files will be developed to establish the College's practice expectations for Members. These Standards will augment the Schedule referenced in the proposed legislative amendments and its regulations. The process for the development of Standards of Practice for refractometry should be consistent with that for dispensing eyewear.

As noted in the "History of Refraction" section, the three eye care colleges were directed to work together to develop Standards of Practice for the performance of refractometry by Opticians. The College recognizes the importance of building consensus whenever possible, however ultimately it is the responsibility of the governing College to set and enforce the Standards of Practice for their own Members. While the COO values all input it receives on proposed policy changes, when conducting its review the College does so only from the perspective of the College's statutory obligation to serve and protect the public interest. This means that the concerns some stakeholders may identify may not be ones that the Council can respond to in setting its rules. The consultation process should be considered as an opportunity to provide meaningful feedback and not as an opportunity to override or diminish the capacity of the COO in setting its own Standards for its members.

21.0 REGULATION CRITERION AS DETERMINED AND PUBLISHED BY HPRAC

When the COO was considering the risk of harm issues related to both the dispensing of eyewear and the performance of refractometry, it considered the "Criteria for Regulating a New Profession under the *RHPA"* document published by HPRAC in January 2005. Opticianry is not a new profession, the dispensing of eyewear is not a new controlled act, nor should refractometry be a controlled act, nonetheless the principles laid out in the HPRAC document were of assistance when considering the referral as it relates to the controlled act of dispensing of eyewear and the performance of refractometry. Accordingly this section will compare these functions to the criterion articulated by HPRAC.

The College of Opticians has demonstrated in this submission that all six criteria have been met, and in most cases exceeded, in considering the dispensing of eyewear or the performance of refractometry and dispensing upon the results.

1. RISK OF HARM

The nature and extent of harm either inherent in the act, or when the act is performed to select populations must be significant

COLLEGE RESPONSE

The COO has provided detailed documentary evidence to establish the inherent risk of harm in dispensing eyewear. The risk of harm is two-fold; risk of harm, both mental and physical to the patient as a result of the controlled act, and risk of harm to the public as a result of the controlled act.

There is not a risk of harm in the performance of refractometry. The risk of harm occurs when contemplating what to do with the results of a refraction. The COO is advocating that refractometry and dispensing on the results of the refraction should be included in an expanded scope of practice for Opticians, provided that Standards of Practice and QA requirements are in place.

2. ALTERNATIVE REGULATORY MECHANISM

Including the act in the RHPA must be a more appropriate response than institutional and/or agency protocols

COLLEGE RESPONSE

Inclusion in the RHPA is the only mechanism for the regulation of dispensing. The industry provides no alternate method of accountability and public protection. The practice setting for most members of the College is an unregulated environment. Until such time as dispensaries are regulated in a similar fashion to Pharmacies, the regulation of the profession and its authorized acts ensure appropriate public protection protocols.

3. SUFFICIENCY OF SUPERVISION
The act must be practiced without direct supervision or supervision exercised through institutional and/or agency protocols

COLLEGE RESPONSE

The act of dispensing by Opiticians is and should be performed separate and distinct from any other controlled act. No supervision is required. Members of the College of Opticians of Ontario practice within their scope of practice autonomously, nor should the profession of Opticianry be supervised by another regulated health professional. The COO is prepared to collaborate with the Ministry of Health and Long-Term Care regarding the regulation of practice settings, however this referral does not .contemplate that regulatory issue.

4. APPROPRIATE ENFORCEMENT
The restriction on the act must be enforceable

COLLEGE RESPONSE

Through inclusion in the RHPA, the act of dispensing is diligently enforced. The College provides a complaints and discipline process as well as a remediation program for remarks of a sexual nature. The RHPA, the Opticianry Act, College specific Regulations, Bylaws, Standards of Practice, the Code of Ethics and Policies govern members of the College. These governance mechanisms are all enforceable within the current legislative framework.

5. EDUCATION AND TRAINING
Practitioners must be adequately trained in current educational programs to perform the act

COLLEGE RESPONSE

Opticians in Ontario have obtained a diploma from a College accredited by the Ministry of Training Colleges and Universities (Georgian College and Seneca College) after completing a minimum of two years of education, including 1, 000 hours of practicum in the workplace. Additionally, Members must provide proof of acceptable continuing education in compliance with the existing Quality Assurance regulation to maintain their registration.

6. ECONOMIC CONSIDERATIONS
Prohibitive costs or unreasonable rigidities should not be imposed on the health care delivery system by controlling the act

COLLEGE RESPONSE

With the exception of a few limited government programs aimed at the most vulnerable members of society, there is no public funding of the dispensing of eyewear thereby imposing no strain or economic burden on the healthcare delivery system.

22.0 CONCLUSION

The College of Opticians of Ontario functions first and foremost in the public interest.
The dynamic and rapidly changing environment of health care in Ontario demands that health care professionals are highly skilled, technologically savvy with strong communication skills.

The COO expectations for its membership are high. The COO demands that its members are knowledgeable, skilled, patient focused professionals who have earned the privilege of self regulation. Through this self regulation, the College achieves, ensures and maintains this very high standard of care which results in excellence in vision care for the citizens of Ontario. Self regulation ensures the principles of accountability, access to care and public protection are maintained during the provision of health care services.

Dispensing eyewear is an integral part of the eye care delivery system. In a model that relies on coordination and collaboration of health care providers, Opticians are well placed to ensure maximum visual acuity, comfort and functionality for their patients. The College of Opticians of Ontario believes we have provided HPRAC with an abundance of material to support our argument that there is inherent risk of harm in all aspects of dispensing eyewear to patients. The most effective way to set and measure standards for the controlled act of dispensing is through continued self regulation under Regulated Health Professions Act, 1991.

Refractometry offers a safe, effective service to the public with no adverse financial strain to the health care delivery system in Ontario. This enhances access and utilizes the skills of trained professionals. Opticians offer increased access, and indeed facilitate integration into the eye care system for many patients. The College of Opticians considers refractometry a key function in the provision of eye care and Opticians should be afforded the opportunity to provide this service to patients while maintaining the standards set by the College.

It is the recommendation of the COO that HPRAC to advise the Minister of Health and Long-Term Care to implement the legislative changes as set out in this submission.