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June 29, 2006

Hon. George Smitherman  
Minister of Health and Long Term Care  
Hepburn Block  
10<sup>th</sup> floor  
80 Grosvenor Street  
Toronto, ON M7A 2C4

Dear Minister Smitherman,

Thank you for the opportunity to comment on the report entitled '*Regulation of Health Professions in Ontario: New Directions*' prepared as advice for your consideration by the Health Professions Advisory Council (HPRAC). The College of Opticians of Ontario (COO) is pleased to make the following submission for your information.

The proposed legislative amendments to the framework of the *Regulated Health Professions Act*, with some adjustments, will provide the regulatory colleges with the enabling mechanisms to ensure consistent quality health for the public in Ontario.

While we are far from satisfied with the recommendations related specifically to the Opticianry portion of the report, the COO is prepared to take the necessary steps to implement the recommendations while ensuring the protection of the public in the eye care field. We are somewhat troubled by several factual errors contained in the report and have attached some points for clarification purposes to assist you in making your decisions based on the most current information available.

The COO thanks you for the opportunity to provide ongoing feedback on this important initiative.

Yours truly,

Caroline MacIsaac-Power RO  
Registrar



**COLLEGE OF OPTICIANS OF ONTARIO**

**SUBMISSION**

**TO**

**THE MINISTER OF HEALTH AND LONG-TERM CARE**

**RESPONSE TO HPRAC'S REPORT:  
*REGULATION OF HEALTH PROFESSIONALS IN ONTARIO:  
NEW DIRECTIONS***

**June 29, 2006**

## **LEGISLATIVE FRAMEWORK**

### **3.The College Structure and Processes**

#### ***3.6 Inquiries, Complaints and Reports Committee***

##### *College Staff Investigation*

The College of Opticians of Ontario (COO) appreciates HPRAC's proposed changes to the *Health Professions Procedural Code* (the Code) that reflect the reality that complaints investigations are conducted by College staff and investigators rather than by the members of the committees themselves. It is not clear from the report or proposed legislative changes to section 25, whether the use of the term "College personnel" means that the Colleges will continue to be permitted to retain outside investigators.

The report does not recognize that College staff and outside investigators often initiate investigations prior to a panel of the Complaints Committee being appointed.

The COO recommends that the proposed section 25 recognize that College staff and in some circumstances, others will be initiating and conducting inquiries and investigations until a panel can be appointed to oversee the matter.

#### ***3.7 The Discipline Committee***

HPRAC recommends that Discipline Committees continue to have the authority to impose appropriate sanctions on members, including sanctions that include remediation. The report then recommends that the Discipline Committee be responsible for specifying the remediation and monitoring compliance with its own remediation orders and return the matter back to the Discipline Committee for another hearing in the instances of non-compliance. The COO believes this could create a perceived conflict of interest if the Discipline Committee is responsible for imposing a remediation order, monitoring compliance, referring non-compliance back to itself and then presiding over the hearing to determine non-compliance. It could be difficult for a member to receive, or be seen to receive, a fair hearing under these circumstances. HPRAC has left out of its recommendations the legislative language to implement the above recommendation.

The COO recommends that the legislation provide that where there is a remediation order, the Committee remain seized of the matter pending compliance with the provisions of its order. The responsibility to monitor orders of the Discipline Committee should be conferred on the Investigations Complaints and Reports Committee (ICR) or the Registrar (as appropriate). They should be given the authority to refer members that it believes to be non-compliant with a discipline order back to the Discipline Committee for a hearing.

#### ***3.9 Quality Committee***

The COO congratulates HPRAC on their recommendations for significant changes to Colleges' Quality Assurance Committees. We fully support the changes but question the placement of 'entry to practice competencies' under the mandate of the Quality Committee. To our thinking, the Quality Committee deals with those issues of health professionals who have successfully met all registration requirements and are engaged in ongoing life-long learning. Entry to Practice Competencies dictate the minimum requirements for first time registration and therefore should be under the jurisdiction of the Registration Committee rather than the Quality Committee.

#### **4.0 Transparency and Accountability**

This is a major theme of the report and is reflected in a number of proposed amendments. Under these amendments each College would be required to provide to the Minister, within the time and in the form that he specifies, the plans, reports, financial statements and information that the Minister requires in order to both administer the Act and manage, evaluate, monitor, allocate resources to or plan for the health system, including delivery of services and human health resources planning. While the COO supports improved transparency and accountability, a potentially large financial and administrative burden would be placed on Colleges in fulfilling these requirements. The imposition of such a burden could detract from the ability of the colleges to fully and effectively implement their regulatory mandate. Accordingly the COO can only support the proposed legislative changes if the Ministry of Health and Long-Term Care is also required to provide funding to reimburse the Colleges for the actual and reasonable costs they incur.

In keeping with the other accountability measures recommended in the report we would support the adoption of recommendations from the previous HPRAC report (*Adjusting the Balance*) that would require the Minister of Health and Long-Term Care to release reports from HPRAC within six months of their receipt. The COO was disappointed by the absence of similar recommendations in the current report.

#### **5.0 Complaints and Reports**

##### *Immediate notice to the member*

Recommendation 22 contained in the New Directions recommends that panels should be required to provide members with "immediate" notice of a complaint or report. This is a change from subsection 25(5) of the Code which simply provides that the member must be given notice, without the added requirement that it be "immediate". While this is generally appropriate, there are situations in which immediate notification of a complaint or report could compromise the integrity of the investigation or the safety of an individual. Examples would be where the allegation is that charts or billing records are being falsified, and it is necessary to preserve the evidence, or where the allegation is that a member is engaged in unauthorized practice or improper delegation and immediate notification could jeopardize the process of gathering information. The COO therefore

recommends that proposed subsection 25(5) permit a brief delay (e.g., 30 days), at the College's discretion, in notifying a member where the delay is necessary to protect the integrity of an investigation or to protect the safety of an individual.

### ***5.3 Alternate Resolution***

The COO supports the spirit of the HPRAC recommendations, namely to clarify and enhance colleges' ability to use Alternative Dispute Resolution (ADR). Nevertheless, the COO takes issue with some of the recommendations and respectfully suggests that certain others be clarified.

Recommendation 41.1 indicates that the ICR Committee should be authorized to "direct" a complainant and a member to participate in ADR. This is inconsistent with the text of the HPRAC Report and other recommendations that correctly note that ADR only works when the parties participate "on an informed and voluntary basis". Accordingly, we believe that the ICR Committee should be legislatively empowered to "authorize" ADR when the parties thereto have given their informed and voluntary consent. Likewise the definition of ADR (recommendation 40) should be amended to read, "includes **voluntary** mediation, conciliation, negotiation..."

The protections put forward in recommendation 41 .6 & 7 do not go far enough. This College recommends that any information, documentation, etc. obtained or generated through an ADR process should not be available for use in college processes and ADR mediators or facilitators should have the same protections. Doing so conforms to the "without prejudice" nature of ADR proceedings and will encourage maximum candor and transparency in ADR.

### ***5.5 Mandatory Reports***

This College has misgivings about the expanded scope of mandatory reporting put forward in recommendations 42 and 43. Our concerns are enumerated as follows:

- Members of one profession cannot be expected to be aware of the professional misconduct regulations of another profession. This becomes even more problematic in the case of laypersons (clinic operators, employers) who HPRAC recommends should also be subject to mandatory reporting requirements.
- The expanded scope of mandatory reporting will likely increase the incidence of frivolous and vexatious complaints.
- There appears to be an error in recommendation 43 that would be corrected by removal of the phrase "obtained in the course of practicing the profession".

The purpose of the mandatory reporting clause is to ensure that serious infractions, such as sexual abuse of patients, is reported to the College and can protect the public from gross misconduct. We recommend that mandatory reporting be limited to misconduct that is likely to expose patients or others to harm, injury or economic loss or sexual abuse.

## **9.0 Governance**

### *Public Members*

HPRAC's analysis of the public appointments process currently in place concludes that significant changes are required. The COO strongly agrees that the current public appointments process contains barriers to providing Lieutenant Governor in Council appointees of requisite quality on a timely basis. Accordingly, we fully support recommendations 57 – 61 contained in *New Directions*.

In addition to supporting the above recommendations, we reiterate our position articulated in our submission to HPRAC on September 27, 2005 where we support a previous HPRAC recommendation (recommendation 10 of *Adjusting the Balance*) that there should be a provision in the profession-specific acts that ensure a majority of professional members make up the composition of Councils.

HPRAC's consultations identified the difficulties encountered by Colleges when public members are not appointed in a timely fashion. This College would like to see, therefore, a legislative change whereby neither the quorum nor the legal ability of the College Council to function is affected if an insufficient number of public appointees are in position.

## **10.0 Scope of Practice Review**

Although we acknowledge that change takes time, the *RHPA* was intended to be a flexible and relatively fluid legislative framework that would allow for and even encourage, the natural evolution of healthcare professions and healthcare delivery. At least as much as any other profession, opticians have been held back in practicing to the full extent of their competencies and in response to client demand. Accordingly, we fully support HPRAC's recommendation that reviews of scopes of practice need to happen more often. In particular, we support the recommendation that a consultation program be developed to enable each profession to assess the validity and currency of its scope of practice and authorized acts and that it report to the Minister of Health and Long-Term Care with recommendations.

## **15.0 Emerging Issues**

The February 7, 2005 referral letter to HPRAC asked that HPRAC keep the Minister of Health and Long-Term Care informed of "any new or emerging issues that HPRAC becomes aware of". Several Colleges included in their submissions regarding the legislative framework portions of the referral letter the serious issue of unauthorized practice by illegal practitioners and the lack of appropriate safeguards in the existing legislation. This issue was also raised during the College consultation meetings held on November 7 & 8 2005. The COO was dismayed to see that HPRAC was noticeably silent on this issue.

*New Directions* contains extensive commentary on the use of the title “Doctor” by a variety of professions. The report makes recommendations regarding protected titles for a number of specific professions, including nurses and psychology associates, but does not discuss or make recommendations regarding the use of words that have regulatory implications.

Recommendation 8 of *Adjusting the Balance* suggested amendments to the *RHPA* to restrict the use of the words “registered”, “regulated”, “licensed” or “certified” in the course of delivering health care services to members of a regulated health profession. As HPRAC pointed out, all of these words can be used to imply regulation. We believe that you should follow the recommendations in *Adjusting the Balance* when you are contemplating implementing HPRAC’s recommendations as a result of this round of consultations. The public must be protected from unregistered persons who would seek to mislead the public with the use of these terms.

We strongly urge you to initiate a referral to HPRAC seeking a full review of the measures needed and already existing in the *RHPA* to protect the public from individuals who hold themselves out as regulated health professionals, perform controlled acts without authorization or use protected titles.

## **REGULATION OF OPTICIANS**

As an established and integral part of the eye care team in Ontario, Opticians have been providing eyewear to the public for more than 100 years. As the profession and indeed health care evolves, the need to embrace technology, collaborative health care environments and maximize allied health capacity have come to the forefront. The COO supports and embraces the concepts of ‘family health teams’, ‘patient centred models’ and ‘collaborative care in education and practice’. In all instances, Opticians in Ontario would fit nicely into these systems for the purpose of providing eye care.

### ***Dispensing Eye Wear***

#### **4.1 Risk of Harm**

While the COO disagrees with certain of HPRAC’s conclusions regarding the risk of harm in dispensing corrective eyewear to adults, we are pleased to see that HPRAC has recommended that dispensing should remain a controlled act under the *RHPA*.

## **6.0 Delegation**

The COO was surprised to see that HPRAC recommended that the Minister exercise his authority under clause 5 (1) (c) of the *RHPA* to direct the College to create a regulation regarding delegation if the College does not propose one (in the given timeframe). While we appreciate the importance of delegation, it was not specifically referenced in the referral letter nor did HPRAC at any time throughout the consultation process engage in discussions with the COO around delegation. Common practice among other Colleges, including the College of Optometrists, is to regulate delegation through policy.

The HPRAC report states that “The College of Opticians ... prohibits members from delegating all or part of the controlled act that is authorized to Opticians” This is not the case. The COO historically has and currently does permit its members to delegate the controlled act of dispensing eyewear. Our delegation policy has been in place since 1998 and has been circulated to all members several times over the years.

The report goes on to state,

*“...it is appropriate for the COO to reduce the current restrictions and enable Opticians to delegate all or part of the authorized act of dispensing to a person who has the knowledge, skill and judgment to perform the act within established guidelines set by the College. This would free members to address other patient-centred obligations and provide increased convenience and access to service for patients and clients.”*

The COO’s rules were developed in cooperation with the College of Optometrists in 1998, and are clearly set out in the Joint Report with the College of Optometrists dated May 1998. A copy of this report was included in our submission to HPRAC on April 30<sup>th</sup>, 2005 (appendix F). At that time of the Joint Report both the COO and the College of Optometrists were told by MOHLTC representatives that neither College required a regulatory amendment to adopt and implement the policy. Our delegation policy was approved by Council and has been published to the membership on a number of occasions. We have attached the reports for your information.

The HPRAC report states that the College of Optometrists has a policy on delegation and that the COO does not. While it is accurate that the College of Optometrists adopted a new policy in 2005, until that time its policy on delegation was the same as the COO’s as articulated in the Joint Report. In 1998 both the COO and the College of Optometrists identified three core cognitive functions of dispensing that could not be delegated. At that time the College of Optometrists and the COO agreed that those three functions must be completed only by health professionals who were authorized to perform the controlled act of dispensing, otherwise the public would be at risk. The policy approved by the College of Optometrists in 2005 eliminated the restriction relating to the three core cognitive functions and now permits all aspects of dispensing to be delegated. The College of Optometrists developed and approved its newest policy in the absence of collaboration or consultation with the COO.

In our submission to HPRAC on September 27, 2005 we discussed the work in which the Federation of Health Regulatory Colleges of Ontario (FHRCO) is currently engaged

regarding delegation and informed HPRAC that we are active participants in, and financial supporters of the Federation Delegation Working Group. The COO supports the concept of delegation within the *RHPA* and is currently engaged in the development of a new policy. **7.0 Refractometry**

The use of public domain across the health care continuum is necessary in maximizing access to healthcare and supporting the quality and the cost effectiveness of health care. Across the spectrum of health care a wide range of services, controlled acts along side public domain acts, regulated professions and unregulated professions work side by side to provide care in many healthcare delivery venues.

The COO, at the direction of Minister Witmer, has banned its members from performing the public domain act of refracting since March 2001. Currently, unregulated and uneducated laypersons perform this same act every day. The COO respected the direction of the past Minister in spite of the fact that Opticians were trained in the principles of refraction and were held accountable by this College for their professional conduct.

HPRAC does not appear to have appreciated that in its submission the COO was not suggesting that Opticians should have the same prescribing rights as optometrists and medical doctors. Our intention was that optician's current ability to adapt prescriptions should be expanded to permit opticians to make minor (i.e. +/- 1 dioptre) adjustments to existing prescriptions based on the results of a refraction for patients who are not part of an at-risk risk category. HPRAC did recognize the necessity of opticians adapting prescriptions (3.1) and their current authority to do so

In making their recommendations, HPRAC accepted the proposition that refraction cannot be separated from a full ocular-visual examination and did not acknowledge that opticians are permitted to refract in two Canadian provinces, specifically, Alberta and British Columbia. The COO respectfully disagrees with HPRAC's recommendations but will work to resolve the issue according to the recommendations in the report.

The COO is pleased that HPRAC has recommended that the MOHLTC revoke the former Minister's letter, and it looks forward to that occurring in the very near future. The COO is working on a standard of practice which will reflect the concerns expressed by HPRAC about "stand-alone" refractions. Such standard of practice would provide that members can perform refractometry but cannot dispense upon the results of a refraction unless the refraction is done in collaboration with the patient's optometrist or physician.

We feel compelled to comment on the practical issues when considering HPRAC's recommendations around collaboration. Currently opticians may work with a physician, however, the College of Optometrists' restrictive conflict of interest regulations prevent collaboration between opticians and optometrists, making it impossible to implement the refraction model recommended in the report. The COO agrees with HPRAC's comment that current conflict of interest regulations that disallow optometrists from associating with opticians must be addressed to facilitate this collaboration. The COO has provided

comments to the College of Optometrists on the latest draft of its conflict of interest regulation. While it is a definite improvement over the existing regulation, among other things the College of Optometrists proposes to continue to prohibit optometrists from being employed by opticians on the basis of perceived conflict of interest, while permitting them to be employed by physicians. It is imperative that such artificial barriers to collaboration among health care providers be removed. The COO is hopeful that the College of Optometrists will make the changes to its regulation that are necessary to facilitate the type of collaboration that HPRAC recommends, including facilitating the ability of opticians to perform refractions as part of a complete eye examination.

### **10.1 Setting Standards of Practice for Refractometry**

The *RHPA* clearly provides the Colleges the authority to draft and enforce standards of practice for their members autonomously with due regard given to issues such as overlapping scopes and collaboration. Collaboration should not be pushed so far as to sacrifice the regulatory independence of individual colleges or to delay changes in regulation. It should also not be used to impose the will of one college over another nor can collaborative working relationships be allowed to interfere with the ability of any college to regulate its own members effectively.

The COO would be pleased to work collaboratively with the College of Optometrists and the College of Physicians and Surgeons to manage this ongoing issue.

# **APPENDIX: F**

**REPORT OF THE COLLEGE OF OPTICIANS OF ONTARIO  
AND THE COLLEGE OF OPTOMETRISTS OF ONTARIO  
IN RESPONSE TO RECOMMENDATIONS 97 AND 98 OF  
THE RED TAPE REVIEW COMMISSION**

**May 20, 1998**

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C Prior Drafts of Report

1 Draft 1, March 27, 1998

2 Draft 2, April 27, 1998, with attached "Reply" to responding submissions

# Report of the College of Opticians of Ontario and the College of Optometrists of Ontario in response to Recommendations 97 and 98 of the Red Tape Review Commission

## Terms of Reference

Dispensing of eyeglasses, contact lenses, or subnormal vision devices (hereinafter "dispensing") is a controlled act under the *Regulated Health Professions Act, 1991* which is authorized to members of the regulated health professions of medicine, opticianry, and optometry. The College of Opticians of Ontario, the College of Optometrists of Ontario, and the College of Physicians and Surgeons of Ontario have historically taken significantly different approaches in their regulation of dispensing by their members. For example, the College of Opticians and the College of Optometrists prohibit the delegation of dispensing, while the College of Physicians and Surgeons of Ontario does not. The Red Tape Review Commission ("RTRC") found the differences in regulatory approaches taken by the Colleges to be illogical. In its final report of January 1997, "*Cutting the Red Tape Barriers to Jobs and Better Government*", the RTRC made the following recommendations relating to dispensing.

*97. The Minister of Health do what is necessary to ensure that the College of Physicians and Surgeons of Ontario, the College of Optometrists of Ontario, and the College of Opticians of Ontario work with the Ministry of Health to develop, within a specified period of time, common principles and practice standards for the dispensing of subnormal vision devices, including a consistent definition of dispensing and common rules for the delegation of dispensing functions to be used by physicians, optometrists and opticians.*

*98. The professional associations be involved as stakeholders in the process; public interests be central to the deliberations; and issues of safety, quality, efficiency and economics be taken into consideration.*

## Process

The Professional Relations Branch (PRB) of the Ministry of Health (MOH) requested a meeting of "Eye Care Provider Groups" on 18 December 1997 to develop an

approach to responding to these recommendations. The groups invited by the PRB to participate in the meeting were the:

- Association of Ontario Ophthalmologists
- College of Opticians of Ontario
- College of Optometrists of Ontario
- College of Physicians and Surgeons of Ontario
- Ontario Association of Optometrists
- Ontario College of Family Physicians
- Ontario Medical Association
- Ontario Opticians Association
- Opticians Association of Canada
- Vision Council of Canada

The PRB proposed a process in which the College of Opticians and the College of Optometrists would act as "Co-chairs". The PRB indicated a degree of flexibility in completion of this process but suggested a target date of the end of February 1998 to report on a possible solution. Subsequently, the PRB extended the target date for completion to the end of March 1998. The PRB proposed that the Co-chairs lead the process with the involvement of relevant stakeholders, including professional associations, in an attempt to reach consensus. The participants agreed to co-operate and work towards a solution.

The relevant stakeholders and others were invited to make submissions to the Co-chairs and to meet on three separate occasions (9 January 1998, 4 February 1998, 1 April 1998) to review the submissions. Subsequent to the 9 January meeting, the Ontario College of Family Physicians ceased to participate and the College of Physicians and Surgeons of Ontario formally withdrew. In its letter of withdrawal, CPSO noted that "the medical profession is otherwise capably represented and that concern for the public interest is a guiding principle for all involved parties".

At the meeting of 4 February 1998, the stakeholders agreed that the Co-chairs would "distil the results of the meeting and define what issues need to be resolved". In so doing, the Co-chairs chose to prepare a draft report for discussion. The draft report was completed on 27 March 1998 after a difficult and lengthy consideration of the highly divergent positions of the various stakeholders. The draft report was

immediately circulated to the stakeholders. The Co-chairs had been instructed that they were working with a deadline of 3 April 1998. They therefore convened a meeting on 1 April with the stakeholders to discuss the draft report. At that meeting, the stakeholders requested, and were given, an additional two weeks in which to provide written submissions on the draft report. At the request of the Co-chairs, the RTRC allowed for a further extension to 15 May 1998 for completion of the process based on the progress that was being made.

The Co-chairs subsequently offered to meet with representatives of all stakeholder groups. Most stakeholder groups agreed to meet with the Co-chairs. Written submissions were received from most stakeholders by the deadline of 15 April. The submissions and the comments from the meetings were taken into consideration by the Co-chairs in preparing a revised draft which was circulated to stakeholders on 27 April 1998. The stakeholders were asked to submit any further comments on the revised draft by 8 May 1998. A number of further comments were received. They were considered by the Co-chairs in preparing this report.

The Co-chairs have diligently attempted to follow the process which was agreed to by the stakeholders in December 1997, and to meet the schedule for reporting. The Co-chairs are grateful for the participation of all the stakeholders, recognizing that the contents of this report will not completely satisfy everyone.

**As a result of this process, the College of Optometrists of Ontario and, particularly, the College of Opticians of Ontario have substantially changed their positions on the regulation of dispensing. They have agreed on a common definition of dispensing and on common principles and essential standards of practice relevant to the practice of dispensing. Most notably, they have set out proposed common rules for delegation of dispensing; this represents a dramatic change from their current prohibition against delegation.**

In the view of the Co-chairs, this document is 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".

Attached to this report is an appendix containing all written responses from the stakeholders, along with both previous drafts of the report.

## **Common Principles**

### **Introduction**

The Co-chairs agree that the regulation of dispensing should follow principles common to the different professions that dispense. In this process, consideration was given to the issue of the risk of harm in dispensing. The Co-chairs note that the Health Professions Legislation Review (HPLR) (often referred to as the Schwartz Commission), spent six years exploring which acts 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 legislature 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.

The Co-chairs agree 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. They recognize that this position is at odds with the views of some of the stakeholders participating in this process. The Co-chairs are of the view that the risk of harm in dispensing derives primarily from the performance of the core cognitive functions and behaviours of dispensing, which are identified herein. The Co-chairs also recognize that the procedures of dispensing other than the core cognitive functions and behaviours present varying risks of harm. Accordingly, in most cases, such procedures could be safely delegated. This is elaborated on in the section entitled "delegation".

### **A Note About the Medical Profession**

The Co-chairs hoped to achieve an agreement of the stakeholders on the common principles, a common definition, common standards of practice, and rules for delegation that would be applicable to the professions that dispense. However, the representatives of medicine who participated in this process made it clear that the existing delegation practices of physicians should not be altered. **The Co-chairs were unable to achieve an agreement with medicine, and therefore nothing in this document should be construed as applying to existing delegation practices in**

medicine. The Co-chairs understand that the MOH is currently addressing the issue of delegation as it applies to all regulated health professions.

### Principles

The Co-chairs have agreed on the following matters of principle about dispensing:

1. **Dispensing presents a risk of harm to the public, as confirmed by its inclusion in the RHPA as a controlled act.**
2. **Varying degrees of risk are present in dispensing.**
3. **Protection of the public from the harm inherent in dispensing is afforded by regulation of all health professionals who are authorized to dispense, accountability of health professionals to their College in maintaining the standards of practice of the profession, and enforcement of the prohibition against unauthorized practice.**
4. **All health professionals who dispense should be under the regulatory control of, and accountable to, a health profession College in order to ensure an appropriate level of public protection from the risk of harm in dispensing.**
5. **Physicians and surgeons, opticians, and optometrists are authorized to perform the controlled act of dispensing.**
6. **The public should have access to safe choices in dispensing as presently provided by three different health care professions.**
7. **The public should be able to expect equitable care in dispensing from any regulated health professional who dispenses.**
8. **The public should be able to anticipate quality dispensing care from any regulated health professional who dispenses.**

The Co-chairs also believe that it is desirable, in the public interest, that there be appropriate statutory and regulatory controls on the place in which members practise, as well as on members who dispense, in much the same way as pharmacies

are subject to statutory and regulatory controls apart from and in addition to pharmacists.

### **Definition**

Several definitions of dispensing were proffered by the participants. The following definition is agreeable to the Co-chairs. This definition will be useful in identifying for members, the courts, and the public the specific nature of the controlled act. Furthermore, the definition will be useful in detailing what only a member is authorized to do within the broader scope of practice of the member's profession.

The definition of dispensing is not intended to describe the scope of practice of any of the three professions authorized to dispense, nor does it set or infer any particular standards of practice in dispensing.

The Co-chairs agree that "dispensing" is the preparation, adaptation, and delivery of eyeglasses, contact lenses, or subnormal vision devices to a person.

The Co-chairs confirm that the word "adaptation", found in the definition, does not include changing the prescription.

### **Standards of Practice**

Standards of practice can be seen as a College's expectation for behaviour of a member in practice. Written standards of practice attempt to reflect the expectation of the College for the usual practice of its members in particular situations. Standards of practice are not formulae for clinical decision-making or care, nor do they suggest a particular clinical outcome for a particular patient. Standards of practice do assist a member in providing high quality services to the public. Each member is responsible for maintaining the standards of practice of the member's profession in dispensing.

The Co-chairs agree that standards of practice in dispensing should include the following:

**In dispensing, a member shall**

- 1. establish a professional relationship with a person prior to dispensing to that person<sup>1</sup>;**
- 2. identify himself or herself to any patient to whom the member dispenses, and within the record of care made and maintained by the member about that patient;**
- 3. determine and record the specifications of the eyeglasses, contact lenses, or subnormal vision devices to be provided to a patient;**
- 4. confirm and record that the eyeglasses, contact lenses, or subnormal vision devices to be provided or delivered to the patient are appropriate; and**
- 5. provide and record the necessary advice, counselling, and associated care to the patient about the use of the eyeglasses, contact lenses, or subnormal vision devices.**

These are the common standards of practice that have been agreed to by the Co-chairs. They are not the only controls or standards of practice that apply to members in dispensing. Each College has the authority to regulate its own members in the public interest in other matters, including professional misconduct, conflict of interest, communications (including advertising), and business practice.

Some stakeholders have suggested that many of these standards could be met by "file review" by a member. The Co-chairs view such an interpretation as being at variance with the intent of the standards. The Co-chairs would not apply that interpretation to these standards for the members of the College of Optometrists of Ontario or the College of Opticians of Ontario.

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<sup>1</sup> Once a professional relationship is established with a person, that person is referred to as a patient.

In response to concerns expressed by some stakeholders, the Co-chairs state that they have no intention of, or interest in, using their authority to circumvent the intent of the RTRC or the intentions of this report.

### **Delegation**

Currently, the College of Opticians of Ontario and the College of Optometrists of Ontario prohibit the delegation of dispensing. The principle on which this prohibition is based is that only members are suitably qualified to dispense and are accountable. Prohibiting delegation is not for the purpose of protecting the scope of practice of any profession, in that three different professions are already authorized to dispense. Furthermore, there are no unregulated groups of persons with appropriate training or experience to dispense.

On the basis of the principles set out in this document, the Co-chairs are now of the view that certain component procedures of dispensing could be delegated and that certain persons can appropriately receive delegation of those component procedures. However, a member should not delegate if, in the member's professional judgement, it is not appropriate to do so, or if to do so would be contrary to the standards of practice of the member's profession, or would place the member in a conflict of interest. For greater clarity, the prohibition against a member delegating when in a conflict of interest means that a member should delegate only when he or she considers it appropriate to do so, and should not delegate if compelled to do so, against the member's professional judgement.

**Core cognitive functions and behaviours in dispensing may not be delegated. A member therefore may not delegate:**

- 1. the determination and recording of the specifications of the eyeglasses, contact lenses, or subnormal vision devices to be provided to a patient;**
- 2. the confirmation and recording of the appropriateness of the eyeglasses, contact lenses, or subnormal vision devices to be provided or delivered to the patient;**

3. **the provision and recording of the necessary advice, counselling and associated care to the patient about the use of the eyeglasses, contact lenses, or subnormal vision devices .**

In the view of the Co-chairs, only physicians, optometrists and opticians have the necessary knowledge, skill, judgement, and accountability to perform the three core cognitive functions of dispensing safely and competently. These are the functions that involve clinical decision making and that result in suitable, efficacious, functional and safe dispensing to a patient.

This prohibition on delegation does not extend to procedures and components of dispensing other than those identified above.

The Co-chairs' decision to permit delegation of certain components of dispensing relies on the presence of appropriate and necessary rules for delegation. In order for the public interest to be served in the provision of safe and high quality dispensing, the Co-chairs agree that common rules for delegation of dispensing should include the following:

1. **A member must have established a professional relationship with a person prior to delegating any part of dispensing for that person (hereinafter the "patient").**

The establishment of a professional relationship between the professional and the patient is a pre-condition of any valid delegation in the health field. It is essential to know one's patient in order to be able to safely provide the core cognitive functions of dispensing. Furthermore, without a professional relationship, there can be no accountability for the dispensing which take place pursuant to delegation. The Co-chairs do not view this requirement as in any way impeding the process of delegation.

2. **A member delegating and the person receiving delegation must each be identified in the record of care made by the member about the patient.**
3. **A member must ensure that the standards of practice of the member's profession are maintained by the person receiving the delegation.**

4. **A member is responsible for any failure on the part of a person receiving delegation to maintain the standards of practice.**
5. **A member must be physically present in the same facility with the person receiving delegation at the time the member delegates tasks in dispensing to that person.**

A member's physical presence at the time of delegation and when delegated acts are being performed on patients is essential in order to protect the public from inaccessible care. Without a member's physical presence, individual members could delegate tasks to any number of unlicensed persons in any number of locations, thereby making themselves inaccessible to the public. The Co-chairs believe that this would be contrary to the public interest.

6. **A member must be physically present in the same facility and available to intervene when a delegated act of dispensing is being performed on a patient.**

A member should always be available when a delegated act is being performed on the patient. This does not mean that the delegated act needs to be supervised. Whether the member intervenes in the delegated act, and to what degree, should be at the member's discretion and judgement. It is not necessary for a member to be present when tasks in dispensing are being performed in the absence of the patient.

7. **A member must ensure that the tasks which the member delegates be patient-specific and appropriate.**

As health services are rendered individually and specifically to patients, so too tasks which the member delegates should be patient specific and appropriate. Delegation of dispensing should not occur when, in the member's professional judgement, delegation is inappropriate, for example, where a patient has a condition of the eye that requires a member's knowledge, skill, and judgement in all aspects of dispensing.

8. **A member must identify to the College, at its request, any person to whom a task of dispensing has been delegated.**

Colleges need to be able to determine whether persons other than members who are dispensing have received a valid delegation. Accordingly, members should be prepared to identify to the College, at its request, persons to whom they have delegated dispensing. This is not intended to interfere with employment relationships, nor is it for the purpose of establishing a registry of persons who receive delegation.

9. **A member must ensure that any person receiving delegation has received training appropriate to the delegated tasks to be performed.**

Members should be responsible and accountable for ensuring that a person to whom dispensing is delegated is properly trained. Neither Co-chair contemplates requiring that there be formal training programs for non-members who dispense by delegation.

### **Conclusion**

The Co-chairs are satisfied that they have received and considered all of the views and submissions from all of the participants in this process. Many of the views and submissions of the stakeholders have been included within this report. However, given the divergent positions of some of the stakeholders, it has not been possible to achieve consensus on all aspects of the recommendations made by the RTRC. The Co-chairs regret that this has led at least one stakeholder to reject the entire process and conclusions herein. Despite this, the Co-chairs believe that this process has been successful in leading to an unprecedented dialogue amongst the stakeholders and a significant breakthrough in establishing appropriate and necessary common principles, a consistent definition of dispensing, common practice standards for dispensing, and common rules for the delegation of dispensing, as called for by the RTRC.

Wednesday, 20 May 1998

Ministry of Health and Long-Term Care

**Consultations on the Sustainability of  
Ontario's Health Care System**

Attendee List – May 17, 2006

Organization	First Name	Last Name	Title
Association of Ontario Midwives	Michael	Heitshu	Acting Executive Director
Association of Ontario Neurologists	Rannjit	Singh	President
Canadian Diabetes Association	Karen	Philp	National Director
Canadian Paraplegic Association, Ontario	William	Adair	Executive Director
Canadian Policy Research Networks	Patrick	Fafard	Research Fellow
College of Opticians of Ontario	Caroline	Maclsaac-Power	Registrar
Health Care Network of Southeastern Ontario	Allan	Katz	Managing Director
Heart and Stroke Foundation of Ontario	Laura	Syron	Vice President, Research Health Promotion
North West Local Health Integration Network	Gwen	DuBois-Wing	Chief Executive Officer
Nurse Practitioners' Association of Ontario	Jane	Sanders	Executive Director
Ontario AIDS Network	Patti	Bregman	Director, Public Policy
Ontario Association of Medical Laboratories	Paul J.	Gould	Chief Executive Officer
Ontario Association of Patient Councils	Theresa	Claxton	Chair
Ontario Children's Health Network	Marilyn	Booth	Executive Director
Ontario College of Family Physicians	Jan	Kasperski	Executive Director and CEO
Ontario Community Support Association	Susan	Thorning	COO
Ontario Federation of Community Mental Health and Addiction Programs	David	Kelly	Executive Director
Ontario Home Care Association	Lori	Lord	
Ontario Joint Policy and Planning Committee	Howard	Baker	
Ontario Kinesiology Association	Conny	Glenn	President
Ontario Long-Term Care Association	Karen	Sullivan	Executive Director

<b>Organization</b>	<b>First Name</b>	<b>Last Name</b>	<b>Title</b>
Ontario Medical Association	Greg	Flynn	
Ontario Pharmacists' Association	Tommy	Cheung	Director, IT E-health
Ontario Physiotherapy Association	Dorianne	Suave	Chief Executive Officer
Ontario Society of Medical Technologists	Carol	Julian	President
Respiratory Therapy Society of Ontario	Shane	Donaldson	Director
Saint Elizabeth Health Care	Shirley	Sharkey	President & CEO
The Arthritis Society, Ontario	Jo-Anne	Sobie	Executive Director
The Kidney Foundation of Canada, Central Ontario Branch	Janet	Bick	Director, Government and Professional Relations
Workplace Safety and Insurance Board	Jane	McCarthy	Vice President