



**COLLEGE OF OPTICIANS OF ONTARIO**

**RESPONSE TO**

**STAKEHOLDER COMMENTS**

**TO THE**

**HEALTH PROFESSIONS REGULATORY ADVISORY**  
**COUNCIL**

**JULY 29, 2005**

## **Introduction**

The College of Opticians of Ontario (the “COO”) has carefully read and considered the submissions made by stakeholders in response to Section E. 2) of the Minister's referral letter to HPRAC dated February 11, 2005. The COO has paid particular attention to those submissions that articulated concerns about or opposition to refractometry being within the legislative scope of practice of Opticianry and the continuation of dispensing eyewear as a controlled act under the *Regulated Health Professions Act*. The COO regrets the tone of some of the submissions, including some from the Optometry profession, in particular those that raise the spectre of inter-professional turf battles and suggest that any stakeholders are motivated exclusively by self-interest.

We are convinced that allowing opticians to refract will enhance access to necessary health-care services and is consistent with one of the stated objectives of the RHPA, namely "(ensuring) that individuals have access to services provided by the health professions of their choice". As a public domain act, it is accepted that there is no risk of harm associated with refraction and, furthermore, it is nonsensical to allow unregulated and untrained individuals to perform refraction while prohibiting opticians from doing so. We are also mindful of the Health Council of Canada's characterization of health human resources as the most pressing challenge facing today's health-care system and the Council's admonition to governments to design a multipronged approach including addressing scope of practice issues so that all health professionals are working to the fullest extent of their professional capability. Finally, prohibiting opticians from refracting would tend to entrench the monopoly that optometry has over the continuum of care in the vision sector, including ocular visual examinations, prescribing and dispensing eyewear.

With respect to dispensing eyewear, the COO is pleased with the evident near-consensus among stakeholders that there is a risk of harm and dispensing eyewear should continue to be a controlled act under the RHPA.

With that as background, there are several points the COO would like to make in response to issues or concerns raised by some stakeholders with respect to the refractometry component of the referral.

## **Specific Issues**

### **Risk of Harm in Dispensing**

It is important to note that of the responses to this referral received by HPRAC only two suggested that there is not a risk of harm in dispensing eyeglasses. They conceded however, that a risk exists for individuals under the age of 13. The OMA states that the risk of harm in dispensing has been the subject of an ongoing debate with “significant divergence of opinion” that do not serve the public interest. It would appear, however,

from the many submissions received that there is indeed a general consensus that there is a risk of harm in dispensing

Even if one accepts the argument that there is minimal risk of harm in the dispensing of eyeglasses to children and adults over the age of thirteen, as the College of Optometrists correctly points out in its submission, there are several other groups for whom the dispensing of eyewear presents a risk of harm. The College of Optometrists submission points out the difficulty in regulating in the patchwork manner that would be required to protect the disparate groups.

### **Definition of Dispensing**

The Vision Council of Canada, in its submission, expresses a concern that there is no definition of dispensing contained within the RHPA. While this is true, the COO does not see this as an issue.<sup>1</sup> As we stated in our original submission the COO considers the definition of dispensing to be “*The preparation, adaptation and delivery of eyeglasses, contact lenses or subnormal vision devices to a person.*” The College of Optometrists concurred with this definition in its submission (page 4). The two regulatory bodies that share the responsibility for regulating the majority of health care practitioners who dispense eyewear in Ontario both agree on a definition that the courts have supported. As the VCC points out in its submission, the Red Tape Commission recommended that the three regulated professions that have dispensing eyewear within their scope of practice should agree to common principles on dispensing. The three regulatory bodies responsible for those professions met in conjunction with stakeholder groups in the late 1990s to do just that. While the CPSO opted out of that process for their own reasons the COO and the College of Optometrists did agree on a common definition. In fact, the definition in the *Wadden* decision is the definition that the two Colleges agreed on during the Red Tape Review of the late 1990s.

The Vision Council’s efforts to downplay the significance of the *Wadden (King Optical)* decision are unconvincing. The case went through three levels of court. The trial judge rejected the evidence of the experts proffered by the defence, and accepted the evidence of the experts proffered by the College (an optician, an optometrist and an ophthalmologist, all of them distinguished in their fields), that beyond a reasonable doubt there was a risk of harm in the dispensing of eyeglasses to adults. His decision was upheld by the Superior Court of Justice and by the Court of Appeal. Whether there was actual harm in the particular case is a red herring - it is *risk* of harm that is the issue.

### **Scope of Practice**

The COO reiterates that if “scope of practice” is a description of what opticians actually do, refractometry is part of the scope of practice of opticians. HPRAC has previously

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<sup>1</sup> “Dispensing” is not unique in this regard. None of the controlled acts contained in the *RHPA* have been defined per se, and many do not have a generally accepted definition.

concluded that the measurement of refractive error of the eye is not within the legislated scope of practice in section 4 of the *Opticianry Act*. However, it did not comment on whether it *should be*- in fact, it specifically declined to address the issue because it was outside the scope of what the Minister had asked it to look at. As HPRAC said in its letter of September 27, 2000 to Elizabeth Witmer, then Minister of Health and Long Term Care:

“Given the very specific nature of the questions in the attached referral letter, HPRAC’s (*sic*) 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 part of a review of a request for expansion of the scope of practice.**” (Emphasis added.)

Accordingly, the COO sees the discussion in stakeholders’ submissions of whether refractometry is within the legislated scope of practice as a sterile exercise. The real issue is whether it should be.

That said, there appears to be a great deal of misconception about the purpose of the scope of practice section in the *Opticianry Act*. Some stakeholders appear to believe that the fact that something is not contained in a scope of practice statement means that members of the profession cannot perform it. This is simply not the case. As HPRAC put it in 2000, the scope of practice defines the “minimum requirements”, as opposed to the “outer boundaries” of Colleges’ activities in relation to governing the professional activities of their members. It is open to Colleges to enact regulations preventing their members from acting beyond the scope of practice of the profession in the course of practicing the profession (*Health Professions Procedural Code*, s. 95(1)(n)). But in the absence of such a regulation, there is no prohibition against members acting beyond their legislated scope of practice. The COO has no such regulation.

In fact, members of regulated health professions engage in public domain acts that are outside their legislated scopes of practice, and within the scope of practice of other professions, all the time. By way of example, the scope of practice of chiropody, as defined in the *Chiropody Act, 1991*, includes treatment of diseases, disorders or dysfunction of the foot by orthotic means. This is the only profession that has orthotics in its legislated scope of practice. Nevertheless, as noted by the president of the Ontario Podiatric Medical Association in his letter to HPRAC of May 25, 2005, many other kinds of health practitioners, including physiotherapists, chiropractors, massage therapists and occupational therapists prescribe, fit and/or dispense foot orthotics. Since the prescription, fitting and dispensing of orthotics is a public domain act, there is no prohibition against members of other professions engaging in it, notwithstanding that there is no specific reference to such practices in their scope of practice statements.

As the COO indicated in its original submission, opticians elsewhere in Canada are now engaged in the measurement of refractive error. While they are not supposed to be doing it in Ontario, this is solely because of the ban imposed by the COO at the direction of the then-Minister of Health. The COO believes that once the regime that it has recommended is implemented, there is no reason why its members should be banned from performing this public domain activity. It is time that the legislated scope of practice reflects what opticians are actually doing. Including “the measurement of refractive error” in the scope of practice statement under the *Opticianry Act* will provide clear statutory authority for the COO to regulate its members’ conduct in this area, including enacting standards of practice governing how its members conduct themselves, as well as defining quality assurance and entry to practice requirements. This is clearly in the public interest.

### **Approaches to Refractometry in British Columbia**

Some stakeholders expressed concerns that the B.C. government's intentions with respect to allowing opticians to refract had been misrepresented. Attached at Appendix A is a copy of the draft regulation. It is our understanding that the B.C. government intends to implement this regulation, or one which is materially the same, within the current calendar year. Opticians in that province continue to perform automated sight tests at this time. They have not been ordered to cease this public domain activity while awaiting regulation changes.

### **Refractometry is Only Part of a Full Eye Health Examination**

The COO agrees with this statement without reservation. The COO emphatically disagrees, however, with certain of the conclusions some stakeholders have derived from that statement.

In the first place, it is both condescending and patronizing to claim that patients cannot be expected to understand that they have not received a full ocular visual examination after a refraction. Patients apparently understand that an examination by their nurse practitioner, podiatrist, chiropractor or physiotherapist is no substitute for a full check-up by their physician. Because of the system of overlapping scopes of practice in the *RHPA*, the same kind of confusion could arguably arise with many professions, but that has not prompted the placing of restrictions on services that those professions are competent to provide. In any event, the COO believes that it is the duty of all of the *RHPA* colleges to inform the public on such matters in order to ensure that they can make intelligent decisions relating to their choice of health-care practitioner and health-care services. Furthermore, the Standard of Practice developed by the College of Opticians of British Columbia (COBC) which the COO will use as a model (expanding the COBC Standard to Practice to include both automated and manual refracting and contact lenses) would require opticians to ensure their patients understand that a refraction is no substitute for a full eye health examination. There is no reason why health professionals cannot educate the public about the credentials of the professional assisting them or the nature and limitations of the services being provided. As our original submission explained, patients

would be required to read, understand and sign a consent form similar to that developed in B.C. that explains what a sight test is and what it is not. (See Appendix B)

In the second place, there is the mistaken belief that optical complications will be missed if the patient receives only a refraction performed by an optician rather than a full eye health examination. Already, in an average month, 8 – 12% of the patients seen by opticians are being referred to either an ophthalmologist or an optometrist due to the presence of more serious health concerns. Earlier this year, the COO conducted a survey of its registrants requesting information relating to the frequency of patient referrals to either an optometrist or an ophthalmologist. The referrals (between 18 – 21% of all patients seen by an optician in an average month) result from the patient not having had a full-ocular visual examination in over 24 months (12 – 16%) or because of the identification of a more serious ocular complication. (See Appendix C for a summary of the complete survey.)

Some stakeholders have expressed concern that Opticians lack the ability to screen patients and, therefore, will not be able to make appropriate referrals to other eye care professionals. The education and experience of Opticians outlined in our original submission on April 29, 2005 clearly shows this is not the case. Opticians do have the requisite knowledge, skill and judgement to appropriately screen patients. In addition, it should be noted that it is considered professional misconduct for Opticians not to refer appropriately.<sup>2</sup>

Finally, a refraction is separable from a full eye health examination. Currently, patients are subject to an unnecessary inconvenience and an unnecessary financial burden since every refraction necessitates a full eye health examination.

### **Refractometry Accomplishes Nothing Without the Ability to Prescribe**

Some groups have stated that the COO is seeking to permit its members to prescribe. As we indicated in our original submission, this is not the case. To suggest, as some parties have, that dispensing based on the results of a refraction is the same as prescribing, is illogical and is inconsistent with the statutory language. Dispensing and prescribing are very different concepts under the legislation. The COO contemplates that members will only be permitted to dispense, based on the results of a refraction, to a patient who has previously had a prescription for corrective eyewear (see pages 38-39 of our original submission). What the optician will do, if s/he finds it to be warranted by the results of the refraction, is to augment the lens powers that were determined by the physician or

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<sup>2</sup> Under the Professional Misconduct Regulation, for the purposes of clause 51(1)(c) of the Health Professions Procedural Code it is considered to be professional misconduct for [13] *Failing to refer a patient to a registered physician when the member recognizes, or ought to have recognized, a condition of the eye or adnexa that appears to require medical examination*” (Regulation 828/93 under the *Opticianry Act, 1991*). Opticians that fail to comply with the Professional Misconduct regulation could be subject to discipline proceedings. If found guilty at such a hearing potential penalties include suspension or revocation of their registration.

optometrist, in order to fine tune visual acuity, without the need for a full-blown eye examination. As stated in the COO's original submission, there will be strict standards of practice in place that will limit the amount of correction that the optician can do without referring the patient back to a physician or optometrist.

Some stakeholders have suggested that dispensing eyewear based on the results of a refraction constitutes "treatment", the determination of the need for which requires "diagnosis" and "prescribing". The COO disagrees that the dispensing of corrective eyewear constitutes "treatment"; if it did, one would expect to find "treatment" within the legislated scope of practice of opticians. For the reasons stated above, its proposal does not involve opticians prescribing. There is no diagnosis involved in the decision to effect a change in the power of lenses based on a change in the measurement of a patient's refractive error. In any event, diagnosis is not a controlled act; the controlled act is *communicating* a diagnosis to an individual identifying a disease or disorder as the cause of symptoms in circumstances in which it is reasonably foreseeable that the individual will rely on the diagnosis. It would be absurd to suggest that opticians who dispense upon their own refraction are communicating a diagnosis to an individual.

### **Assessment**

Certain stakeholders have suggested that because the public domain act of "assessment" is not part of the legislated scope of practice for opticians, that somehow means that opticians are not permitted to measure refractive error. There are a number of flaws in this analysis.

As noted above, in the absence of a regulation barring members from performing acts outside the scope of practice, there is no restriction on opticians performing such acts, so long as they are in the public domain. Accordingly, the fact that "assessment" does not appear in section 4 of the *Opticianry Act* does not mean that opticians do not or cannot engage in it.

In any event, the COO is asking for an increase in its legislated scope of practice to include "measurement of refractive error". The COO does not consider "measurement of refractive error" to be "assessment". The actual measurement is nothing more than the performance of a test. The interpretation of the results is nothing more than the interpretation or evaluation of data. The measurement of refractive error does not involve any assessment of a patient's health care condition for treatment purposes. By way of analogy, the legislated scope of practice for medical laboratory technology involves the performance of laboratory investigations and the evaluation of the technical sufficiency of the investigations and their results. The scope of practice statement in the *Medical Laboratory Technology Act* says nothing about assessment, which demonstrates that the generation and analysis of data does not involve assessment.

### **Portability of Data Generated from a Refraction**

The COO, like the College of Opticians in British Columbia, believes that the results of the measurement of refractive error should be provided to the patient. However, the results do not constitute a prescription, and the patient would not be able to “fill” it at another location. The patient could, however, provide the information to his or her physician or optometrist so that the physician or optometrist has a record of the changes in the patient’s refractive error.

### **Medical Necessity of Ocular Health Examination**

The College of Optometrists takes issue with the COO’s statement that the de-listing of regular eye examinations from OHIP indicates that the government is of the view that periodic eye examinations are not medically necessary. The document that the College of Optometrists cites in denying that statement is a government backgrounder that refers to eye examinations as “less critical”; this supports what the COO stated.

Section 45 of the *Health Insurance Act* of Ontario permits the Lieutenant Governor in Council to make regulations, including (e) “governing insured services, including specifying those services that are not insured services.” It was a regulation made under the authority of that section that excluded periodic eye examinations from the definition of insured services. Subsection 45(3.3) of the *Health Insurance Act* provides that a regulation made under clause (1)(e) cannot include a provision that would disqualify the Province of Ontario under the *Canada Health Act*, for contribution by the Government of Canada because the Plan would no longer satisfy the criteria under that Act.

The *Canada Health Act* requires provinces’ health care insurance plans to satisfy certain criteria in order for the province to qualify for a full cash contribution from the federal government. One of the criteria is that the insurance plan must be comprehensive- this means that it must ensure all insured health services provided by hospitals, medical practitioners or dentists, and, where the law of the province permits, similar or additional services rendered by other health care practitioners. “Insured health services” means, among other things, “physician services”. The definition of “physician services” is “any medically required services rendered by medical practitioners”. In other words, in order to comply with the *Canada Health Act*, OHIP must insure all medically required services rendered by medical practitioners.

Since, (a) delisting a medically required service could disqualify the Province of Ontario from contribution by the Government of Canada under the *Canada Health Act*, and (b) doing so is prohibited by subsection 45(3.3) of the *Health Insurance Act*, it follows that when the government delisted eye examinations from OHIP, it was because it had concluded that they were not medically necessary.



## **Conclusion**

In summary, we believe that a consensus exists for the continuation of dispensing eyewear as a controlled act under the *RHPA*.

In the case of refractometry, we think a compelling case has been made for explicit inclusion of refractometry within the legislative scope of practice of Opticianry. The public will benefit from enhanced access to and choice among providers. The COO is clearly prepared to develop and approve a Standard of Practice that will provide significant public protection and transparency.