Ontario Optometric Jurisprudence Resource Binder

Updated: May 2021

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Study Questions

(Updated May 2018)

Applicants may wish to use the following questions to assist them in preparing for the Jurisprudence Exam. Please note that applicants are also expected to be familiar with the Policies and Guidelines in Section 4 of the Ontario Optometric Jurisprudence Resource Binder, as well as the documents in the Optometric Practice Reference.

I. Governance (Governance pg. 1)

- Do professionals have a different legal standard imposed on them?
- What does it mean to have a fiduciary duty to your patients?
- What is professional self-regulation and how does it protect the public interest?
- What is the structure of the College?
- What is the role of Council?
- How does the role of a public member of Council differ to that of a professional member of Council?

II. Key Legislation

A. Regulated Health Professions Act (RHPA pg. 3)

- What are the goals of the RHPA?
- What are the duties of the Minister?

Controlled Acts (RHPA pg. 23)

- What are "controlled acts"?
- Who can perform a controlled act?
- What is the purpose of the "harm clause"?

(RHPA pg. 25)

Objects of the College

- What are the objects of the College? (Code pg. 44)

Complaints and Reports (Code pg. 69)

- What is the difference between a complaint and a report?
- Who can complain to the College?
- How is a complaint made?
- What discretion does the College have?
- How is the investigation conducted?
- What are the possible outcomes?
- What right to appeal is there?

Discipline (Code pg. 77)

- What is the role of the Discipline Committee?
- How does a matter come before the Discipline Committee?
- What acts of professional misconduct are specified in the Code?
- Why are Discipline hearings normally open to the public?
- If allegations are proven, what are the possible sanctions that may be imposed?
- Is there any right to appeal?

Sexual Abuse

- What is the definition of sexual abuse? (Code pg. 44)
- What are the College's responsibilities? (Code pg. 102)
- What are the reporting obligations of regulated health professionals? (Code pg. 100)
- What are the results at Discipline? (Code pg. 83)

Additional Mandatory Reporting under RHPA (Code - pg. 100)

- Other than for matters related to sexual abuse, what are the RHPA's mandatory reporting requirements?

B. Optometry Act

Scope of Practice (Optometry Act pg. 13)

- What is the scope of practice of optometry?
- Why is this significant?

Authorized Acts (Optometry Act pg. 13)

- What are the controlled acts authorized to optometry?

Prescribed Diseases (Optometry Act pg. 33)

- How is "prescribed diseases" defined in the Act?

Designated Drugs and Standards of Practice (Optometry Act pg. 18)

- What are the standards of practice related to:
  - The patient health record?
  - Treatment of glaucoma?
  - Referral to a physician or hospital?

General Regulation

i. Records (Optometry Act pg.30)
   - What types of records are required?
   - What information is required to be kept?
   - How long must patient records be retained?
   - When are you required to release a copy of the patient record?
   - What are the requirements for electronic records?

ii. Quality Assurance (Optometry Act pg. 34)
   - What are the requirements of a Quality Assurance program under the RHPA? (RHPA pg. 95)
   - What are the components of the College's Quality Assurance Program?

- In what situations is a member required to undergo a Practice Assessment?

Professional Misconduct **(**Optometry Act pg. 23**)**

- What acts of professional misconduct are specified in the Regulation?
- What are the limitations placed on advertising?
- What are the limitations placed on practice names?
- Who does the Conflict of Interest Regulation capture?
- What does the Conflict of Interest Regulation control, and why?
- Why is it important to consider conflict of interest in the healthcare sector?

Standards of Practice

i. Use of Pharmaceuticals (OPR 4.4)
   - What restrictions do Optometrists have regarding the use of drugs?
   - What could be the consequences if drugs were misused?

ii. Delegation and Assignment (RHPA pg. 24 & OPR 4.3)
   - Under what conditions can an optometrist delegate a controlled act?
   - Under what conditions can an optometrist receive delegation?

iii. Optometric Prescriptions (OPR 5.2)
   - What information must be included in an optometric prescription?
   - When is it appropriate to include an expiry date?

Registration (Optometry Act pg. 44)

- What are the entry-to-practice requirements for optometry?
- What is the significance of a non-exemptible requirement?
- What are the conditions on a certificate of registration?

C. College Bylaws

- Who is eligible to stand for election to Council?
- Who is eligible to vote in College elections?
- What is included in the College Register?
- What is professional liability insurance and why is it important? (Bylaws – page 64)
- What amount of professional liability insurance is required?

III. Other Legislation

D. Health Insurance Act (Other Legislation pg. 39)

- If an optometrist 'opts out' of OHIP, can they set their own fees for insured services?
- What services are insured for optometrists? (OHIP Schedule)
- What services are not insured services?

E. Health Care Consent Act

(Other Legislation pg. 16)

- What is “capacity”?
- What are the elements of valid consent?
- What do you do if your patient is incapable?

F. Aeronautics Act

(Other Legislation pg. 3)

- What are the reporting requirements for an optometrist under this Act?
- What obligation does the pilot have that the driver doesn’t?

G. Highway Traffic Act

(Other Legislation pg. 93)

- What are the reporting requirements for an optometrist under this Act?
- How does the reporting requirement relate to patient confidentiality?

H. Child and Family Services Act

(Other Legislation pg. 6)

- What is the obligation placed on optometrists by this Act?
- When is a child in need of protection?

I. Health Protection and Promotion Act

(Other Legislation pg. 88)

- What are the reporting requirements under this Act?

J. Personal Health Information Protection Act

(Other Legislation pg. 103)

- What is the difference between implied and expressed consent?
- What is the ‘circle of care’?
- What should an optometrist do if a breach occurs?

Please bring a piece of identification bearing your photograph to the examination.

Governance

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Governance

The Healthcare Delivery System in Ontario

Regulation

Regulated professionals are governed by law and are accountable for the care they provide. There are mandatory mechanisms in place to ensure regulated professionals are competent at registration and on an ongoing basis. Unregulated care providers are not accountable to a regulatory body. There are no mandatory mechanisms to ensure unregulated care providers have appropriate training or education, or to ensure that they practise safely.

Professional Self-Regulation

Under self-regulation, the government delegates to the profession the power to regulate its members. The College acts as an agent of government in this regard. Government recognizes that the profession has the special knowledge required to set standards and judge the conduct of its members through peer assessment. Self-regulation is contingent on the profession having a commitment to the philosophy of the primacy of public protection.

Since 1919, optometry has been a regulated profession in Ontario. Key legislation governing the profession includes the *Regulated Health Professions Act,* (which is the umbrella legislation under which twenty-six health regulatory colleges exist) and the *Optometry Act,* (under which Optometry regulations are made).

The Role of the College in Self-Regulation

As noted above, the roles and powers of the College are set out in legislation. In general, the College is granted the power to:

- set and enforce standards of professional practice and conduct;
- determine entry to practice requirements; and
- monitor and promote ongoing competence of members and the quality of the profession.

The College protects the public and the public interest and is accountable to the public through the government.

Expectations of a Professional

The word ‘profession’ refers to a distinct group whose members possess special skills or knowledge in an advanced area of learning. There are a number of characteristics of a profession, including:

- a prescribed and accepted educational program for entry to practice;
- registration with a licensing authority that brings with it implied initial competence and on-going accountability;
- right to title or some form of title protection;
- exclusivity or the right to practice in a particular field; and
- self-governance whereby the profession has been delegated the privilege and authority to govern its members, including ensuring members maintain the standard of practice through practice assessments and peer review.

Professionals are generally held to a higher legal standard than other members of the public precisely because they possess special skills and knowledge that cause the public and, for health professionals, their patients, to place trust and confidence in them. Health professionals are expected to place the needs of patients above their own self-interest. All professionals are responsible for ensuring that their knowledge, skill and judgment meet an accepted level of competence throughout their professional careers.

The Patient-Practitioner Relationship
The patient-practitioner relationship is the basis on which healthcare services are delivered. That relationship can be described as contractual when the professional accepts an individual as a patient. It may be worth noting that regulated health professionals are not obliged to treat every person who seeks their care, with the possible exception of emergencies.

This relationship between patient and practitioner is often described as "fiduciary." This means that the relationship is based on trust and the practitioner's faithful commitment to the patient's best interest. This fiduciary relationship arises when a person is dependent on the professional due to his or her expertise. There is an expectation that the professional will act in the best interests of the patient and not in his/her own self-interest.

The patient/practitioner relationship is imbalanced in that the patient is in a more vulnerable position owing to the trusting nature of the relationship. It is important that professional boundaries are maintained in this relationship. Codes of Ethics for professionals serve to protect the vulnerable and the sick from exploitation.

Key Legislation Governing Optometry in Ontario

Regulated Health Professions Act (RHPA)
The RHPA and its schedules, including the Health Professions Procedural Code, is the umbrella legislation that establishes a detailed and uniform framework for the regulation of the health professions in Ontario. Provisions found here are common to all of the health colleges, including information about the objects of a College, statutory committees and the processes to be used for complaints and discipline.

The RHPA consists of three parts. The main part (the Act proper) contains provisions relating to the duties of the Minister of Health and two different review bodies, the Health Professions Regulatory Advisory Council and the Health Professions Appeal and Review Board. Schedule 1 provides a list of the self-governing health professions and Schedule 2, the Health Professions Procedural Code, contains provisions relating to the operation of the colleges, patients' rights and remedies, and the rights and obligations of members of the health colleges.

Optometry Act

Each health profession has its own profession-specific Act. The *Optometry Act* includes the scope of practice of optometry, the controlled acts authorized to optometrists and other administrative issues such as fines and regulation making powers.

The General Regulation includes regulations relating to patient records and defines prescribed diseases (for the purposes of the scope of practice and authorized acts). It also includes detailed regulations regarding the College's Quality Assurance program, building on the general requirements in the RHPA.

The Professional Misconduct Regulation outlines acts of professional misconduct specific to the profession, including conflict of interest, and the Registration Regulation provides detailed information regarding the requirements for becoming registered in Ontario, as well as conditions for maintaining registration on an ongoing basis.

The Designated Drugs Regulation designates the drugs that optometrists are authorized to prescribe. Only those optometrists, who have met the requirements established by the College to perform the controlled act of prescribing drugs, are authorized to prescribe drugs. The Regulation includes a list of drugs that optometrists are authorized to prescribe.

College Council and Committees

Role of the College Council

Council's job is to ensure proper administration of the *Regulated Health Professions Act* and the *Optometry Act* and its regulations. Council members make decisions and establish policies that are in the public interest and in accordance with relevant legislation.

Council members fall into two categories: professional members (optometrists) elected by their peers through regional elections, and public members who are appointed by the Lieutenant-Governor-in-Council (Provincial Cabinet). Public members bring a public perspective to Council discussions, whereas professional members are able to contribute their knowledge of the optometric profession and the settings in which it is practiced.

Council is made up of eight or nine elected professional members, seven or eight appointed public members and one representative selected from the University of Waterloo School of Optometry and Vision Science. All Council members are appointed to at least one statutory committee. They may also be asked to serve on standing and ad hoc committees.

College Committees

The *Regulated Health Professions Act* (RHPA) requires Colleges to establish seven statutory committees. In addition, the College can and does establish non-statutory committees to help meet the mission and objects of the College. The terms of reference and composition of these non-statutory committees is determined by Council.

The composition of the College's statutory committees is found in the College By-laws. College committees are made up of Council members (both professional and public) and additional professional members who are not on Council but who have volunteered to serve as a committee member. All Committee members are appointed by Council on the recommendation of the Executive Committee.

All committee members participate as full voting members of their committees and work with other committee members in managing committee work in a timely and expeditious manner. All committees are accountable to Council and provide a report to Council at every Council meeting.

Executive Committee

The Executive Committee is a statutory committee made up of at least three professional Council members and two public Council members elected by Council at the start of the College business year in January. The Registrar attends all Executive meetings as staff support.

The Executive Committee is an intermediary between Council, staff and committees. The role of the Executive is to 'execute' the Council's wishes. That means ensuring that resources are allocated appropriately and that staff and committees are moving the work of the College forward. The committee also acts in the capacity of a finance committee, overseeing the budget and the allocation of funds to be spent during the fiscal year.

Between meetings of Council, the Executive Committee has all the powers of the Council with respect to any matter that, in the Committee's opinion, requires immediate attention. However, the Executive Committee does not have the authority to make, amend or revoke a regulation or by-law.

Registration Committee

The Registration Committee is a statutory committee responsible for the entry-to-practice process of the profession in Ontario and some of the processes by which members maintain their registration over the course of their careers. The Committee is comprised of four professional members, one of whom is a member of Council, and two public members of Council.

Inquiries, Complaints and Reports Committee

The Inquiries, Complaints and Reports Committee (ICRC) is a statutory committee responsible for the investigation and disposition of complaints and reports filed with the College about the conduct of an optometrist. The Committee is comprised of six professional members, one of whom is a member of Council, and four public members of Council.

Quality Assurance Committee

The Quality Assurance Committee is a statutory committee charged with the responsibility of administering the Quality Assurance Program. The primary purpose of the Committee is to ensure that members are providing quality optometric care to their patients. The Committee does this by assessing members' practices and by evaluating their clinical ability.

In addition to administering the Quality Assurance Program, the Quality Assurance Committee articulates and publishes standards of practice and clinical practice guidelines (the Optometric Practice Reference).

Discipline Committee

The Discipline Committee is a statutory committee that adjudicates allegations of incompetence or professional misconduct made against a member. Cases are referred to the Discipline Committee by the Inquiries, Complaints and Reports Committee. The Committee is comprised of Council members who have not been appointed to ICRC, plus an additional five professional members who are not on Council.

Patient Relations Committee

The Patient Relations Committee is a statutory committee that administers the Patient Relations Program to promote awareness among members and the public of the College's position that any form of abuse of a patient, whether sexual or otherwise, is viewed as professional misconduct that will not be tolerated. The Committee also administers the Patient Relations Fund for Therapy and Counseling which is available to patients who have been sexually abused by their optometrist. The Committee is comprised of four professional members of whom one is a member of Council, and three public Council members.

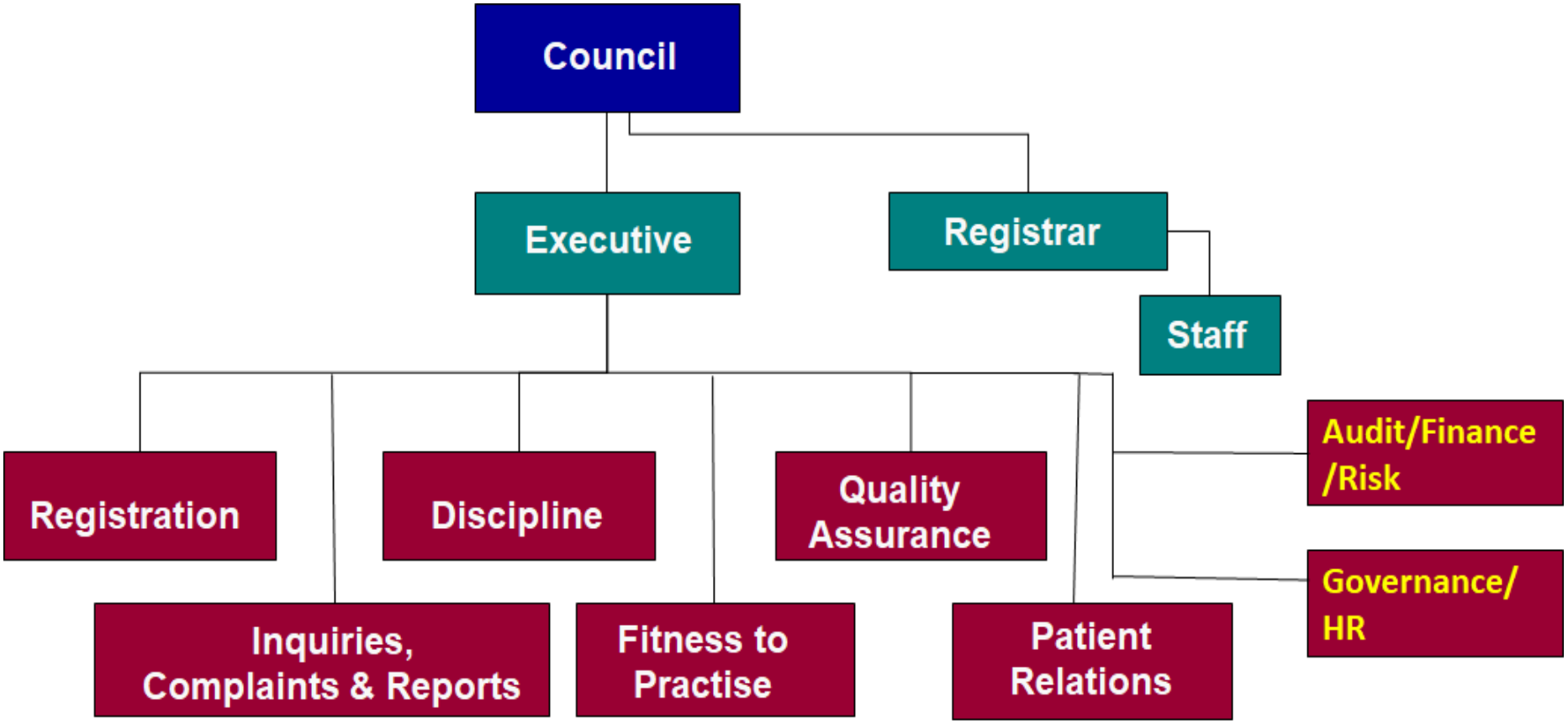
Fitness to Practise Committee

The Fitness to Practise Committee is a statutory committee made up of two professional members, one of whom is a member of Council, and one public member of Council. The Committee is an adjudicative body that holds hearings to determine whether a member has the capacity to practise optometry.

Governance/HR and Audit/Finance/Risk Committees

The Governance/HR and Audit/Finance/Risk committees were established in January 2019 as standing committees.

College Organizational Chart



Key Legislation

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Regulated Health Professions Act (RHPA)

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Regulated Health Professions Act (RHPA)

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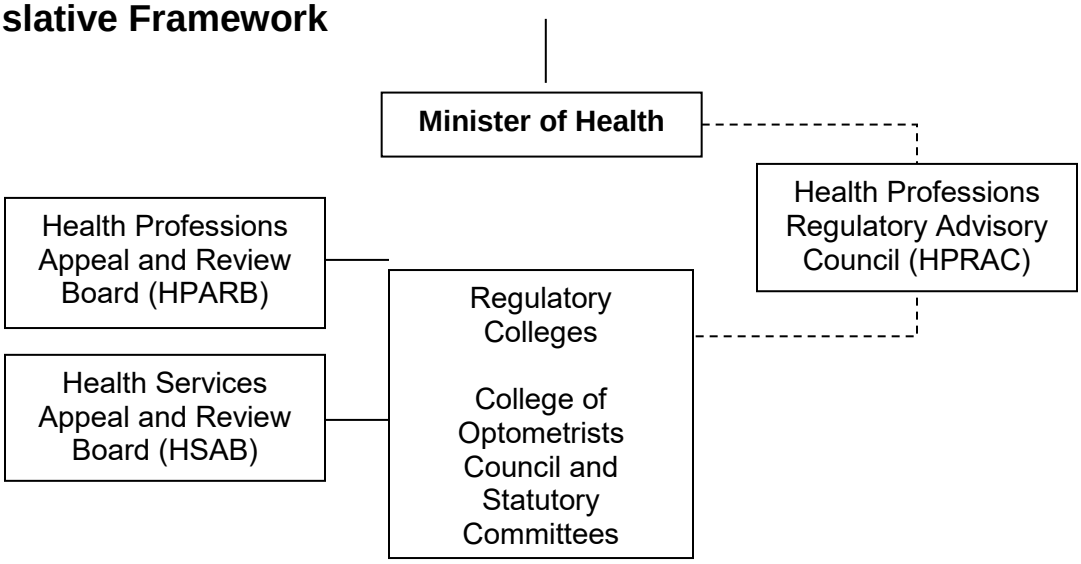
The RHPA consists of three parts. The main part (the Act proper) contains provisions relating to the duties of the Minister of Health and two different review bodies, the Health Professions Regulatory Advisory Council and the Health Professions Appeal and Review Board. Schedule 1 provides a list of the self-governing health professions and Schedule 2, the Health Professions Procedural Code, contains provisions relating to the operation of the colleges, patients' rights and remedies, and the rights and obligations of members of the health colleges.

The primary goal of the RHPA is to protect the public from unqualified, unfit and unethical health professionals. It is also designed to maximize consumer freedom of choice of health care provider and to enhance the efficiency and flexibility with which regulated and unregulated providers are utilized within the healthcare system. It has provisions designed to eradicate the sexual abuse of patients, and it ensures equity among health professions by providing consistency across the health professions.

Legislative Framework



The Minister of Health and Long-Term Care
It is the duty of the Minister to ensure that:
- health professions are regulated and coordinated in the public interest;
- appropriate standards of practice are developed and maintained;
- individuals have access to services provided by the health professions of their choice; and

- individuals are treated with sensitivity and respect in their dealings with health professionals, Colleges and the Health Professions Appeal and Review Board.

Health Professions Regulatory Advisory Council (the Advisory Council)
The Health Professions Regulatory Advisory Council (the Advisory Council) was created to assist the Minister of Health and Long-Term Care. The Advisory Council is made up of persons appointed by the Lieutenant-Governor-in-Council (Cabinet) on the Minister's recommendation. They provide advice on which professions become/stay regulated, suggested amendments to the RHPA or a health profession Act, matters concerning the health Colleges' quality assurance programs, or any other matter referred to them by the Minister. A person who is or has been a member of a Council or College is not eligible to sit on the Advisory Council.

Health Professions Appeal and Review Board (HPARB)
The Health Professions Appeal and Review Board is made up of individuals appointed by the Lieutenant-Governor-in-Council on the recommendation of the Minister of Health and Long-Term Care. Decisions of the Registration Committee and the Inquiries, Complaints and Reports Committee (except those referred to the Discipline Committee) may be appealed to this body. A person who is or has been a member of a Council or College is not eligible to sit on HPARB.

Health Services Appeal and Review Board (HSAB)
There is a second appeal board that is created under the *Ministry of Health Appeal and Review Boards Act*, not the RHPA. The Health Services Appeal and Review Board has five or more persons appointed by the Lieutenant-Governor-in-Council. Decisions of the Optometry Review Committee may be appealed to this body.

Controlled Acts

The RHPA contains important prohibitions relating to the performance of certain healthcare acts and procedures called 'controlled acts.' All of the controlled acts are potentially harmful and most of the controlled acts are related to physical harm.

The system of controlled acts in Ontario is unique. Most jurisdictions define the activities within a profession's scope of practice and then prohibit anyone other than licensed practitioners of the profession from practising within that scope. This restrictive model prevents any overlap of scope from one profession to another.

In Ontario, the RHPA identifies 13 controlled acts and then each health profession Act identifies which of the controlled acts can be performed by members of that profession. The controlled acts authorized to optometry can be found in the *Optometry Act*. Members of some professions, such as medical

doctors, are authorized to perform almost all of the controlled acts. Members of

other health professions, such as dieticians or dental technologists, are not authorized to perform any of the controlled acts.

The controlled acts model protects the public interest by ensuring that only authorized professionals may perform potentially harmful acts, while allowing some overlapping scope of practice from one profession to another. Having more than one profession authorized to provide certain health services ensures greater choice for the public seeking those services. These overlapping scopes provide the public with a broader choice of healthcare professions. It is important to note that a controlled act may also be performed if it has been delegated by an authorized professional to another person.

Harm Clause (Treatment, etc., where risk of harm)

The ‘harm clause’ prohibits a person other than a regulated health professional treating within his or her scope of practice from providing treatment or advice in circumstances in which it is reasonably foreseeable that serious bodily harm may result, either from the treatment/advice or from an omission from them. This clause prevents non-regulated individuals from providing care (treatment or advice) if it is reasonably foreseeable that harm may result, and it also prevents regulated health professionals from practising outside their scope of practice.

The harm clause does not apply to controlled acts that have been appropriately delegated.

There are some exceptions to the controlled acts and the harm clause, such as rendering first aid in an emergency, treating a member of your household, or fulfilling the requirements to become a member of a health profession under the supervision of a member of the profession. This is what allows students to learn their profession.

Confidentiality and Immunity

Confidentiality provisions in the RHPA apply to College staff, councillors and committee members. The requirement is for these individuals to keep confidential all information that comes to their knowledge in the course of fulfilling their duties for the College. There are some exceptions when confidential information may be disclosed, including:

- the information is already available to the public under the RHPA, a health profession Act or the *Drug and Pharmacies Regulation Act*;
- the disclosure is being made to a profession’s governing body inside or outside of Ontario; and
- the person to whom the information relates has given written consent to the disclosure.

Additional exceptions are found in paragraph 36 of the RHPA.

It is important to note that the confidentiality provisions of the RHPA apply only to individuals carrying out the work of the College. There is other legislation for healthcare professionals relating to confidentiality of patient health information.

Immunity from prosecution is given to College staff, councillors and committee members for actions and decisions made in good faith. This provision is particularly important given the nature of the activities and decisions associated with College work. For example, when considering a matter of professional misconduct, a member's reputation and/or livelihood may be at stake. As long as staff, councillors and committee members act with due diligence and in good faith, they cannot be successfully sued for damages.

Objects of the College

The Health Professions Procedural Code (Schedule 2 of the RHPA) sets out 11 objects for Colleges. These objects are akin to a business plan and give guidance to Colleges as to their role and function. It is important to note that the Code specifies that a duty of the College is to "serve and protect the public interest".

The structure of the College is designed to carry out the objects. For example, the Registration Committee manages activities related to object #2 (to develop, establish and maintain standards of qualification for persons to be issued certificates of registration) and the Quality Assurance Committee manages activities related to object #4 (to develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among members).

Registration and Quality Assurance under the Code

The Health Professions Procedural Code (the Code) includes provisions related to all of the statutory committees. Two of these committees, Registration and Quality Assurance, have general provisions in the Code and more detailed, profession-specific information in the *Optometry Act*.

Registration information in the Code deals with fair practices, ensuring the registration process is fair and transparent. It describes the process for appeals of the decisions of the Registration Committee to the Health Professions Appeal and Review Board, and it outlines the information that must be kept in the College Register. This includes every member's name and business information, a notation of every revocation or suspension of a certificate of registration, and the result of every disciplinary proceeding.

With regard to Quality Assurance (QA), the Code requires the College to have a quality assurance program, it discusses members' obligation to cooperate with QA assessors, and it deals with the collection and disclosure of information for

the purposes of the quality assurance program.

These registration and quality assurance processes are common to all the health regulatory colleges. More specific Registration and QA information related to optometry is found in the *Optometry Act*.

Inquiries, Complaints and Reports

The Inquiries, Complaints and Reports Committee is a statutory committee required by the Code under the RHPA. The Committee deals with complaints and reports made against a member of the College.

Complaints
Anyone can lodge a complaint against a member of the College. Complaints must be in writing or on disk or tape (permanent format). The ICRC must investigate every complaint, though they have discretion to refuse to investigate a complaint if it is frivolous, vexatious or made in bad faith. The investigation is conducted in a manner that provides fairness and balance between the parties. The ICRC is required to reach a decision within 150 days.

Reports
If a matter comes to the attention of the Registrar which leads the Registrar to believe that a member has committed an act of professional misconduct or is incompetent, he or she may ask the ICRC to approve the appointment of an investigator to obtain additional information. The Registrar's report is submitted to the ICRC and the member who is the subject of the report is given an opportunity to respond. The ICRC will then consider the information and render a decision in the matter.

Powers
The powers of the ICRC are limited. For both complaints and reports, they may refer specified allegations of professional misconduct or incompetence to the discipline committee, they may refer a member to a panel of the ICRC for incapacity proceedings, they may caution the member with a written or verbal caution, and/or they may take other action that is not inconsistent with the health profession Act. For example, they may require a member to undertake specific continuing education activities. One thing the ICRC cannot do is require a practitioner to refund money or to pay compensation to the complainant. These issues are for the courts to decide.

Decisions
Any ICRC decision regarding a complaint can be appealed to the Health Professions Appeal and Review Board (the Board). The appeal may be made by the member, the complainant, or both. The exception is when the ICRC refers a complaints matter to the Discipline Committee (for professional misconduct) or to a panel of the ICRC for incapacity proceedings. There is no appeal mechanism for ICRC decisions related to reports.

When considering an appeal of an ICRC complaints decision, the Board considers two matters: the adequacy of the investigation and the

reasonableness of the decision. The Board may confirm all or part of the Committee's decision, make recommendations to the committee, and/or require the committee to exercise any of its powers.

Discipline

The Discipline Committee deals with allegations of professional misconduct or incompetence. Definitions of professional misconduct and incompetence are found in both the Health Professions Procedural Code and the regulations made under the profession specific acts, including the *Optometry Act*. The Code identifies the following acts of professional misconduct:

- being found guilty of an offence that is relevant to the member's suitability to practise;
- having a finding of professional misconduct in another jurisdiction that would be professional misconduct in Ontario;
- sexually abusing a patient;
- committing an act of professional misconduct as defined by the regulations.

The Professional Misconduct Regulation under the *Optometry Act* identifies more than 55 acts of professional misconduct related to relationships with and care of patients, advertising, business practices, etc.

Incompetence occurs when a member's professional care of a patient demonstrates a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted. Incompetence is similar to professional misconduct but is considered to be more serious. Often, it comes to light from a pattern of practice.

Referrals to the Discipline Committee come from the ICRC. When a matter is referred to the Discipline Committee, a formal discipline hearing is conducted by a panel of the Committee. The parties to the hearing are the College and the member. The panel may permit other individuals to participate to the extent determined by the panel.

Members of the public may attend a discipline hearing unless there is a reason to exclude them, such as ensuring that the safety of a person is not jeopardized. Making hearings open to the public helps ensure the transparency of the process. With an open and transparent process, it is clear that the College is upholding the public interest, not the interest of the member.

The standard of proof at a discipline hearing is the civil standard of "balance of probabilities" and must be based on clear, cogent and convincing evidence.

Sanctions that may be imposed on members by the Discipline Committee include a reprimand or terms, conditions or limitations being imposed on the member's certificate of registration. Registration may also be suspended or revoked. A fine of up to $35,000 (paid to the Ontario Minister of Finance, not the College) may be imposed, and the member may be required to pay the College's expenses. If the professional misconduct relates to certain physical forms of sexual abuse, a recorded reprimand and revocation of the member's certificate of registration are mandatory.

A decision of the Discipline Committee may be appealed to the Divisional Court.

Sexual Abuse

In the RHPA Code, "sexual abuse" of a patient is defined as:

(a) sexual intercourse or other forms of physical sexual relations between the member and the patient;
(b) touching of a sexual nature, of the patient by the member; or
(c) behavior or remarks of a sexual nature by the member towards the patient.

Members should understand that sexual nature does not include touching, behaviour or remarks that are of a clinical nature and appropriate to the clinical service provided.

Mandatory Reporting of Sexual Abuse

Under the Health Professions Procedural Code of the *Regulated Health Professions Act* (RHPA), an optometrist shall file a report if he or she has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different health profession has sexually abused a patient. No report is required if the optometrist does not know the name of the health professional who would be the subject of the report. If an optometrist is required to file a report because of reasonable grounds obtained from a patient of the health professional, the optometrist shall use his or her best efforts to advise the patient of the requirement to file the report before doing so. Operators of facilities where one or more health professionals practise also have mandatory reporting requirements if the person who operates the facility has reasonable grounds to believe that a health professional practising at the facility has sexually abused a patient.
Mandatory reports of sexual abuse must contain:

- the name of the person filing the report,
- the name of the health professional who is the subject of the report,
- an explanation of the alleged sexual abuse, and
- the name of the patient who may have been sexually abused if she or he

has consented in writing to include his or her name in the report.

The report must be made to the Registrar of the College of the health professional who is the subject of the report within 30 days after the obligation to report arises. If the individual making the report has reasonable grounds to believe that the health professional will continue to sexually abuse the patient, or will sexually abuse other patients, then the report must be filed immediately.

If the mandatory report is being made by a regulated health professional providing psychotherapy to the alleged abuser, the report must contain the opinion of the treating professional, if he or she is able to form one, as to whether the allegedly abusing health professional is likely to sexually abuse patients in the future. In addition, the treating professional must immediately file a report with the alleged abuser's College if he or she ceases to provide psychotherapy to the health professional who was the subject of the initial report.

What the RHPA (Code) Says...

85.1 (1) A member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient.
(2) A member is not required to file a report if the member does not know the name of the member who would be the subject of the report.
(3) If a member is required to file a report because of reasonable grounds obtained from one of the member's patients, the member shall use his or her best efforts to advise the patient of the requirement to file the report before doing so.

85.2 (1) A person who operates a facility where one or more members practise shall file a report in accordance with section *85.3 if the person has reasonable grounds to believe that a member who practices at the facility has sexually abused a patient.*

85.3 (1) A report required under section 85.1 or 85.2 must be filed in writing with the Registrar of the College of the member who is the subject of the report.
(2) The report must be filed within thirty days after the obligation to report arises unless the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, in which case the report must be filed forthwith.
(3)The report must contain,

(a) the name of the person filing the report;
(b) the name of the member who is the subject of the report;

(c) an explanation of the alleged sexual abuse:
(d) if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4).

(4) The name of a patient who may have been sexually abused must not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name

85.6 No action or other proceeding shaft be instituted against a person for filing a report in good faith under section 85.1, 85.2.

What the RHPA (Code) Means...

It is the optometrist's responsibility to treat the patient with sensitivity and respect and obtain as much detail as the patient is willing or able to divulge. Help the patient focus and let him or her talk, allowing the patient to unburden him or herself.

The patient must be informed of the optometrist's obligation under the law to bring the alleged incident to the attention of the named health professional's College, but that the patient's identity will be kept just between the two of you unless the patient provides written permission stating otherwise.

It is prudent to file a report as soon as possible after learning of the alleged incident. Although the Act states that the optometrist has up to thirty days to report the alleged incident, the sooner the better for everyone involved. If there is reason to believe that the sexual abuse of patients will continue, the report must be filed immediately.

The optometrist may suggest that the patient report the incident to the appropriate regulatory college. However, the optometrist's obligation under the law does not change if the patient says that she or he will file a report, the optometrist must still report the incident as relayed by the patient.

The Report

The College suggests that the report be on the optometrist's professional letterhead and addressed to the Registrar of the appropriate College. The report must include:

Part A: The optometrist's name and the name of the alleged abuser; and

Part B: What the patient said: the details of the alleged abuse.

Part C: the name of the patient, but only if the patient or the patient's representative gives consent.

It is the optometrist's responsibility to report the alleged incident as told by the patient, not to judge whether or not an incident occurred.

The optometrist must attempt to obtain written consent of the patient or the patient's representative, if applicable. The consent should be informed consent, requiring the optometrist to explain why the consent is sought and the likely results of giving the consent.

Formal written consent on a separate Consent to Release Information Form may seem threatening to the patient and may not foster a high level of compliance. A possible solution is to make a simple notation on a sheet of your professional letterhead that the patient (or representative) has agreed to the release of her or his name, and have it signed by the patient (or representative). This document should be attached to, and retained with, the report.

If the patient or patient's representative has given consent to release her or his name, it is recommended that the report have a statement at the beginning such as:

The information contained in this Report is disclosed to you with the full knowledge and consent of …….. [name of patient or patient's representative] who informed me of this alleged incident during a visit to my office on ..... [date]

When a patient does not consent to have his or her name included, a statement such as the following may be included:

The information provided in this Report is done so with the full knowledge of my patient or her or his representative who has forbidden me from releasing her or his name.

As these reports are not part of the patient's clinical record, it is suggested that a copy of each letter be filed elsewhere and kept for a minimum period of ten years. Further, the report is the property of the member and shall not be left in the practice when the member either moves or retires.

A member who fails to make a report when required to do so may face an allegation of professional misconduct. Those who make a required report are given protection from reprisals in the workplace and from civil actions or proceedings, provided the report is made in good faith.

The Patient Relations Program

As part of the measures for eradicating sexual abuse of patients, the RHPA requires the College to maintain a Patient Relations Program with measures for preventing or dealing with sexual abuse of patients including:

- educational requirements for members;

- guidelines for the conduct of members with their patients;
- training for College staff; and
- provision of info to the public.
-

The Patient Relations Program is administered by the Patient Relations Committee which is also responsible for the Patient Relations Fund established to provide funding for therapy and counseling for persons who, while patients, were sexually abused by members.

Mandatory Reporting by Facilities and Employers

Mandatory reporting of sexual abuse is outlined in detail, above. However, reporting requirements also arise in the following situations:

- a person who operates a facility where one or more members practice has reasonable grounds to believe that a member who practises at the facility is incompetent, incapacitated, or has sexually abused a patient,
- a person terminates the employment or revokes, suspends or imposes restrictions on the privileges of a member or dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity, or
- a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but did not do so because the member resigned or voluntarily relinquished his or her privileges.

All mandatory reports must be filed within thirty days. If the report is related to sexual abuse and the reporter has reason to believe that the sexual abuse of patients will continue, or if the report is related to incompetence or incapacity and the reporter believes patients may be harmed, the report must be filed immediately. The report must include:

- the name of the individual making the report,
- the name of the member who is the subject of the report,
- an explanation of the alleged sexual abuse, incompetence or incapacity, and
- the name of the patient who is the subject of the report.

As noted above, if the report is related to a patient who may have been sexually abused, the name of the patient may only be included if written consent is obtained.

Where the conduct in question involves an optometrist, the report must be made to the Registrar of the College of Optometrists. Reports of the professional misconduct, incompetence or incapacity of other health professionals must be made to the Registrar of the health professional's College.

Those who make a required report are given protection from reprisals in the

workplace and from civil actions or proceedings, provided the report is made in good faith.

Self-Reporting Requirements

Optometrists must report whether they belong to other regulatory/licensing bodies – inside and outside of Ontario – and whether they have any findings of professional misconduct against them by another professional body. Optometrists will also be required to report any charges as soon as reasonably practicable after they have occurred, and any resulting bail conditions. The report will be required to contain certain details, including information regarding the status of any proceedings with respect to the charge.

Fitness to Practise

The Fitness to Practise Committee receives referrals from the ICRC related to members who are incapacitated, i.e., that the member is suffering from a physical or mental condition or disorder that make it desirable in the interest of the public that the member no longer be permitted to practice or that the member's practice be restricted. Unlike the Discipline process, Fitness to Practise hearings are normally private, with the College and the member the only parties.

If the Fitness to Practise Committee finds a member to be incapacitated, it may order the member's certificate of registration to be revoked or suspended, or to have terms, conditions or limitations attached for either a fixed or indefinite period of time. A decision of the Fitness to Practise Committee may be appealed to the Divisional Court.

Spousal Exemption Regulation

Ontario Regulation 566/20 (Spousal Exemption Regulation), which was submitted to the provincial government in 2014, came into force on October 8, 2020.This regulation change allows optometrists to treat their spouses without the treatment constituting sexual abuse. It does not imply, nor should it be considered a recommendation that optometrists treat their spouse. The regulation only applies to those who qualify as a "spouse" (and not other romantic/sexual relationships) and stipulates that any sexual relationships remain out of the practice setting.

For the purposes of this regulation, "spouse" is clearly outlined in the Code as:

- A person to whom the optometrist is married, or
- A person who has lived with the optometrist in a conjugal relationship outside of marriage continuously for at least three years.

The College will be developing guidance in the near future to addresses important considerations when treating family members.

Regulated Health Professions Act, 1991

S.O. 1991, CHAPTER 18

Consolidation Period: From May 1, 2018 to the e-Laws currency date.

Last amendment: 2017, c. 25, Sched. 9, s. 115.

Legislative History: 1993, c. 37; 1996, c. 1, Sched. G, s. 27; 1998, c. 18, Sched. G, s. 1-23; 2000, c. 26, Sched. H, s. 3; 2000, c. 42, Sched., s. 29-40; 2001, c. 8, s. 217-225; 2002, c. 24, Sched. B, s. 25; 2004, c. 3, Sched. B, s. 11; 2005, c. 28, Sched. B, s. 2; 2006, c. 19, Sched. C, s. 1 (1); 2006, c. 19, Sched. L, s. 10, 11 (2); 2006, c. 27, s. 18; 2006, c. 31, s. 35; 2006, c. 35, Sched. C, s. 116; 2007, c. 10, Sched. B, s. 21; 2007, c. 10, Sched. L, s. 32; 2007, c. 10, Sched. M; 2007, c. 10, Sched. O, s. 14; 2007, c. 10, Sched. P, s. 20; 2007, c. 10, Sched. Q, s. 14; 2007, c. 10, Sched. R, s. 19; 2008, c. 18; 2009, c. 6; 2009, c. 24, s. 33; 2009, c. 26, s. 24; 2009, c. 33, Sched. 6, s. 84; 2009, c. 33, Sched. 18, s. 17 (2), 29; 2010, c. 15, s. 241; Table of Public Statute Provisions Repealed Under Section 10.1 of the *Legislation Act, 2006*; 2013, c. 9; 2014, c. 14, Sched. 2, s. 9-12; 2015, c. 8, s. 38; 2015, c. 18, s. 2, 3; 2015, c. 30, s. 28; 2016, c. 6, Sched. 1, s. 4; 2017, c. 2, Sched. 9, s. 10-12; 2017, c. 11, Sched. 5; 2017, c. 25, Sched. 6, s. 17; 2017, c. 25, Sched. 9, s. 115.

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Table
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Schedule 2 Health professions procedural code

Interpretation

1 (1) In this Act,

"Advisory Council" means the Health Professions Regulatory Advisory Council; ("Conseil consultatif")

"Board" means the Health Professions Appeal and Review Board under the *Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998*; ("Commission")

"certificate of authorization" means a certificate of authorization issued under this Act or the Code; ("certificat d'autorisation")

"Code" means the Health Professions Procedural Code in Schedule 2; ("Code")

"College" means the College of a health profession or group of health professions established or continued under a health profession Act; ("ordre")

"Council" means the Council of a College; ("conseil")

"health profession" means a health profession set out in Schedule 1; ("profession de la santé")

"health profession Act" means an Act named in Schedule 1; ("loi sur une profession de la santé")

"health profession corporation" means a corporation incorporated under the *Business Corporations Act* that holds a valid certificate of authorization issued under this Act or the Code; ("société professionnelle de la santé")

"member" means a member of a College; ("membre")

"Minister" means the Minister of Health and Long-Term Care; ("ministre")

"personal health information" has the same meaning as in section 4 of the *Personal Health Information Protection Act, 2004*; ("renseignements personnels sur la santé")

"personal information" means personal information within the meaning of the *Freedom of Information and Protection of Privacy Act*. ("renseignements personnels") 1991, c. 18, s. 1 (1); 1998, c. 18, Sched. G, s. 1; 2000, c. 42, Sched., s. 29; 2006, c. 19, Sched. L, s. 11 (2); 2007, c. 10, Sched. M, s. 1; 2009, c. 33, Sched. 18, s. 17 (2); 2017, c. 11, Sched. 5, s. 1.

Hearing not required unless referred to

(2) Nothing in this Act shall be construed to require a hearing to be held within the meaning of the *Statutory Powers Procedure Act* unless the holding of a hearing is specifically referred to. 1991, c. 18, s. 1 (2).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 1 - 01/02/1999

2000, c. 42, Sched., s. 29 - 01/11/2001

2006, c. 19, Sched. L, s. 11 (2) - 22/06/2006

2007, c. 10, Sched. M, s. 1 - 04/06/2007

2009, c. 33, Sched. 18, s. 17 (2) - 15/12/2009

2017, c. 11, Sched. 5, s. 1 - 30/05/2017

Administration of Act

2 The Minister is responsible for the administration of this Act. 1991, c. 18, s. 2.

Duty of Minister

3 It is the duty of the Minister to ensure that the health professions are regulated and co-ordinated in the public interest, that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. 1991, c. 18, s. 3.

Code

4 The Code shall be deemed to be part of each health profession Act. 1991, c. 18, s. 4.

Powers of Minister

5 (1) The Minister may,

(a) inquire into or require a Council to inquire into the state of practice of a health profession in a locality or institution;

(b) review a Council's activities and require the Council to provide reports and information;

(c) require a Council to make, amend or revoke a regulation under a health profession Act, the *Drug and Pharmacies Regulation Act* or the *Drug Interchangeability and Dispensing Fee Act*;

(d) require a Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the health profession Acts, the *Drug and Pharmacies Regulation Act* or the *Drug Interchangeability and Dispensing Fee Act*. 1991, c. 18, s. 5 (1); 2009, c. 26, s. 24 (1).

Council to comply with Minister's request

(2) If the Minister requires a Council to do anything under subsection (1), the Council shall, within the time and in the manner specified by the Minister, comply with the requirement and submit a report. 1991, c. 18, s. 5 (2).

Regulations

(3) If the Minister requires a Council to make, amend or revoke a regulation under clause (1) (c) and the Council does not do so within sixty days, the Lieutenant Governor in Council may make, amend or revoke the regulation. 1991, c. 18, s. 5 (3).

Idem

(4) Subsection (3) does not give the Lieutenant Governor in Council authority to do anything that the Council does not have authority to do. 1991, c. 18, s. 5 (4).

Expenses of Colleges

(5) The Minister may pay a College for expenses incurred in complying with a requirement under subsection (1). 1991, c. 18, s. 5 (5).

Section Amendments with date in force (d/m/y)

2009, c. 26, s. 24 (1) - 15/12/2009

College supervisor

5.0.1 (1) The Lieutenant Governor in Council may appoint a person as a College supervisor, on the recommendation of the Minister, where the Minister considers it appropriate or necessary. 2014, c. 14, Sched. 2, s. 9.

Factors to be considered

(2) In deciding whether to make a recommendation under subsection (1), the Minister may consider any matter he or she considers relevant, including, without limiting the generality of the foregoing,

(a) the quality of the administration and management, including financial management, of the College;

(b) the administration of this Act or the health profession Act as they relate to the health profession; and

(c) the performance of other duties and powers imposed on the College, the Council, the committees of the College, or persons employed, retained or appointed to administer this Act, the health profession Act, the *Drug and Pharmacies Regulation Act* or the *Drug Interchangeability and Dispensing Fee Act*. 2009, c. 26, s. 24 (2).

Notice

(3) At least 30 days before recommending to the Lieutenant Governor in Council that a College supervisor be appointed, the Minister shall give the College a notice of his or her intention to make the recommendation and in the notice advise the College that it may make written submissions to the Minister. 2009, c. 26, s. 24 (2).

Review of submissions

(4) The Minister shall review any submissions made by the College and if the Minister makes a recommendation to the Lieutenant Governor in Council to appoint a College supervisor, the Minister shall provide the College's submissions, if any, to the Lieutenant Governor in Council. 2009, c. 26, s. 24 (2).

Term of office

(5) The appointment of a College supervisor is valid until terminated by order of the Lieutenant Governor in Council. 2009, c. 26, s. 24 (2).

Powers of College supervisor

(6) Unless the appointment provides otherwise, a College supervisor has the exclusive right to exercise all the powers of a Council and every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or the *Drug Interchangeability and Dispensing Fee Act*. 2009, c. 26, s. 24 (2).

Same

(7) The Lieutenant Governor in Council may specify the powers and duties of a College supervisor appointed under this section and the terms and conditions governing those powers and duties. 2009, c. 26, s. 24 (2).

Additional powers of College supervisor

(8) If, under the order of the Lieutenant Governor in Council, the Council continues to have the right to act respecting any matters, any such act of Council is valid only if approved in writing by the College supervisor. 2009, c. 26, s. 24 (2).

Right of access

(9) A College supervisor has the same rights as a Council and the Registrar in respect of the documents, records and information of the College. 2009, c. 26, s. 24 (2).

Report to Minister

(10) A College supervisor shall report to the Minister as required by the Minister. 2009, c. 26, s. 24 (2).

Minister's directions

(11) The Minister may issue one or more directions to a College supervisor regarding any matter within the jurisdiction of the supervisor, or amend a direction. 2009, c. 26, s. 24 (2).

Directions to be followed

(12) A College supervisor shall carry out every direction of the Minister. 2009, c. 26, s. 24 (2).

Section Amendments with date in force (d/m/y)

2009, c. 26, s. 24 (2) - 15/12/2009

2014, c. 14, Sched. 2, s. 9 - 01/08/2016

***Fair Access to Regulated Professions and Compulsory Trades Act, 2006* not applicable**

5.1 The *Fair Access to Regulated Professions and Compulsory Trades Act, 2006* does not apply to any College. 2006, c. 31, s. 35 (1); 2017, c. 2, Sched. 9, s. 10.

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (1) - 01/03/2007

2017, c. 2, Sched. 9, s. 10 - 22/03/2017

***Ontario Labour Mobility Act, 2009* not applicable**

5.2 The *Ontario Labour Mobility Act, 2009*, except sections 21 to 24, does not apply to any College. 2009, c. 24, s. 33 (1).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (1) - 15/12/2009

Reports

Annual report

6 (1) Each College and the Advisory Council shall report annually to the Minister on its activities and financial affairs. 1998, c. 18, Sched. G, s. 2 (1).

(2) REPEALED: 2007, c. 10, Sched. M, s. 2 (1).

Audited financial statement

(3) Each College's annual report shall include an audited financial statement. 1998, c. 18, Sched. G, s. 2 (2).

Content and form

(4) The Minister may specify the content and form of the annual reports submitted by the College and the Advisory Council and, where the Minister has done so, the annual reports shall contain that content and be in that form. 2007, c. 10, Sched. M, s. 2 (2).

Minister may publish information

(5) The Minister may, in every year, publish information from the annual reports of the Colleges. 2007, c. 10, Sched. M, s. 2 (2).

No personal information

(6) Information from the annual reports published by the Minister shall not include any personal information. 2007, c. 10, Sched. M, s. 2 (2).

Additional audits

(7) The College and the Advisory Council shall be subject, at any time, to any other audits relating to any aspect of its affairs as the Minister may determine to be appropriate, conducted by an auditor appointed by or acceptable to the Minister. 2009, c. 26, s. 24 (3).

Auditor to submit results

(8) The auditor shall submit the results of any audit performed under subsection (7) to the Minister and the College. 2009, c. 26, s. 24 (3).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 2 (1, 2) - 01/02/1999

2007, c. 10, Sched. M, s. 2 (1, 2) - 04/06/2009

2009, c. 26, s. 24 (3) - 15/12/2009

ADVISORY COUNCIL

Advisory Council

7 (1) The Advisory Council is established under the name Health Professions Regulatory Advisory Council in English and Conseil consultatif de réglementation des professions de la santé in French.

Composition

(2) The Advisory Council shall be composed of at least five and no more than seven persons who shall be appointed by the Lieutenant Governor in Council on the Minister's recommendation.

Chair and vice-chair

(3) The Lieutenant Governor in Council shall designate one member of the Advisory Council to be the chair and one to be the vice-chair. 1991, c. 18, s. 7.

Qualification of members

8 A person may not be appointed as a member of the Advisory Council if the person,

(a) is employed under Part III of the *Public Service of Ontario Act, 2006* or by a Crown agency as defined in the *Crown Agency Act*; or

(b) is or has been a member of a Council or College. 1991, c. 18, s. 8; 2006, c. 35, Sched. C, s. 116 (1).

Section Amendments with date in force (d/m/y)

2006, c. 35, Sched. C, s. 116 (1) - 20/08/2007

Terms of members

9 (1) Members of the Advisory Council shall be appointed for terms of two years. 1991, c. 18, s. 9 (1).

Replacement members

(2) A person appointed to replace a member of the Advisory Council before the member's term expires shall hold office for the remainder of the term. 1991, c. 18, s. 9 (2).

Reappointments

(3) Members of the Advisory Council are eligible for reappointment. 1991, c. 18, s. 9 (3).

(4) REPEALED: 2007, c. 10, Sched. M, s. 3.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 3 - 04/06/2009

Remuneration and expenses

10 The members of the Advisory Council shall be paid the remuneration and expenses the Lieutenant Governor in Council determines. 1991, c. 18, s. 10.

Duties of the Advisory Council

11 (1) The Advisory Council's duties are to advise the Minister and no other person on any issue from the matters described in clauses (2) (a) to (f), but only if the Minister decides to refer the issue to the Advisory Council in writing, seeking its advice, and in no other circumstances. 2009, c. 26, s. 24 (4).

Matters that may be referred

(2) The matters that the Minister may refer to the Advisory Council are,

(a) whether unregulated professions should be regulated;

(b) whether regulated professions should no longer be regulated;

(c) suggested amendments to this Act, a health profession Act or a regulation under any of those Acts and suggested regulations under any of those Acts;

(d) matters concerning the quality assurance programs undertaken by Colleges;

(e) each College's patient relations program and its effectiveness; and

(f) any matter the Minister considers desirable to refer to the Advisory Council relating to the regulation of the health professions. 2009, c. 26, s. 24 (4).

Section Amendments with date in force (d/m/y)

2009, c. 26, s. 24 (4) - 15/12/2009

Referrals to the Advisory Council

12 (1) The Minister may refer any issue within the matters described in clauses 11 (2) (a) to (e) to the Advisory Council that a Council or person asks the Minister to refer, and the Minister may refer any other issue to the Advisory Council that the Minister determines is appropriate. 2009, c. 26, s. 24 (5).

Advice for Minister only

(2) Unless the Minister or this Act provides otherwise, the Advisory Council shall provide its advice to the Minister and no other person, and shall not provide advice on any issue other than the issue referred to it by the Minister. 2009, c. 26, s. 24 (5).

Form and manner

(3) If the Minister refers an issue to the Advisory Council for advice, the Advisory Council shall provide its advice to the Minister only in the form and manner specified by the Minister. 2009, c. 26, s. 24 (5).

Section Amendments with date in force (d/m/y)

2009, c. 26, s. 24 (5) - 15/12/2009

Notice of amendments to Councils

13 (1) If the Minister refers a suggested amendment to this Act, a health profession Act or a regulation under any of those Acts or a suggested regulation under any of those Acts to the Advisory Council, the Minister shall give notice of the suggestion to the Council of every College within ten days after referring it.

Submissions to Advisory Council

(2) A Council may make written submissions to the Advisory Council with respect to a suggestion within forty-five days after receiving the Minister's notice of the suggestion or within any longer period the Advisory Council may specify. 1991, c. 18, s. 13.

Function is advisory only

14 The function of the Advisory Council is advisory only and no failure to refer a matter or to comply with any other requirement relating to a referral renders anything invalid. 1991, c. 18, s. 14.

Procedure

15 (1) The Advisory Council shall sit in Ontario where and when the chair designates.

Idem

(2) The Advisory Council shall conduct its proceedings in the manner it considers appropriate. 1991, c. 18, s. 15.

Employees

16 (1) Such employees as are considered necessary for the proper conduct of the affairs of the Advisory Council may be appointed under Part III of the *Public Service of Ontario Act, 2006*. 2006, c. 35, Sched. C, s. 116 (2).

Experts

(2) The Advisory Council may engage experts or professional advisors to assist it. 1991, c. 18, s. 16 (2).

Section Amendments with date in force (d/m/y)

2006, c. 35, Sched. C, s. 116 (2) - 20/08/2007

Secretary

17 (1) The Advisory Council shall appoint one of its employees as the Secretary.

Duties

(2) The Secretary's duties are,

(a) to keep a record of matters that the Minister has referred to the Advisory Council;

(b) to have the custody and care of the records and documents of the Advisory Council;

(c) to give written notice of suggested amendments to this Act, a health profession Act or a regulation under any of those Acts and suggested regulations under any of those Acts that have been referred to the Advisory Council to persons who have filed, with the Secretary, a request to be notified; and

(d) to carry out the functions and duties assigned by the Minister or the Advisory Council. 1991, c. 18, s. 17.

HEALTH PROFESSIONS BOARD

18-22 REPEALED: 1998, c. 18, Sched. G, s. 3.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 3 - 01/02/1999

23 REPEALED: 1998, c. 18, Sched. G, s. 3.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 3 - 01/02/1999

2007, c. 10, Sched. B, s. 21 - 04/06/2007

Investigations and expert advice

24 (1) REPEALED: 1998, c. 18, Sched. G, s. 4.

Investigators

(2) The Board may engage persons who are not public servants employed under Part III of the *Public Service of Ontario Act, 2006* to carry out investigations under paragraph 3 of subsection 28 (5) of the Code. 2006, c. 35, Sched. C, s. 116 (3); 2007, c. 10, Sched. M, s. 4 (1).

Experts

(3) The Board may engage persons who are not public servants employed under Part III of the *Public Service of Ontario Act, 2006* to provide expert or professional advice in connection with a registration hearing, complaint review or registration review. 2006, c. 35, Sched. C, s. 116 (3).

Independence of experts

(4) A person engaged under subsection (3) shall be independent of the parties, and, in the case of a complaint review, of the Inquiries, Complaints and Reports Committee. 2007, c. 10, Sched. M, s. 4 (2).

Advice disclosed

(5) The nature of any advice, including legal advice, given by a person engaged under subsection (3) shall be made known to the parties and they may make submissions with respect to the advice. 1991, c. 18, s. 24 (5).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 4 - 01/02/1999

2006, c. 35, Sched. C, s. 116 (3) - 20/08/2007

2007, c. 10, Sched. M, s. 4 (1, 2) - 04/06/2009

25 REPEALED: 1998, c. 18, Sched. G, s. 5.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 5 - 01/02/1999

26 REPEALED: 2007, c. 10, Sched. M, s. 5.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 5 - 04/06/2009

PROHIBITIONS

Controlled acts restricted

27 (1) No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,

(a) the person is a member authorized by a health profession Act to perform the controlled act; or

(b) the performance of the controlled act has been delegated to the person by a member described in clause (a). 1991, c. 18, s. 27 (1); 1998, c. 18, Sched. G, s. 6.

Controlled acts

(2) A "controlled act" is any one of the following done with respect to an individual:

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

i. beyond the external ear canal,
ii. beyond the point in the nasal passages where they normally narrow,
iii. beyond the larynx,
iv. beyond the opening of the urethra,
v. beyond the labia majora,
vi. beyond the anal verge, or
vii. into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. 1991, c. 18, s. 27 (2); 2007, c. 10, Sched. L, s. 32; 2007, c. 10, Sched. R, s. 19 (1).

Exemptions

(3) An act by a person is not a contravention of subsection (1) if the person is exempted by the regulations under this Act or if the act is done in the course of an activity exempted by the regulations under this Act. 1991, c. 18, s. 27 (3).

Same

(4) Despite subsection (1), a member of the Ontario College of Social Workers and Social Service Workers is authorized to perform the controlled act set out in paragraph 14 of subsection (2), in compliance with the *Social Work and Social Service Work Act, 1998*, its regulations and by-laws. 2007, c. 10, Sched. R, s. 19 (2).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 6 - 01/02/1999

2007, c. 10, Sched. L, s. 32 - 04/06/2007; 2007, c. 10, Sched. R, s. 19 (1, 2) - 30/12/2017

Delegation of controlled act

28 (1) The delegation of a controlled act by a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

Idem

(2) The delegation of a controlled act to a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession. 1991, c. 18, s. 28.

Exceptions

29 (1) An act by a person is not a contravention of subsection 27 (1) if it is done in the course of,

(a) rendering first aid or temporary assistance in an emergency;

(b) fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession;

(c) treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;

(d) treating a member of the person's household and the act is a controlled act set out in paragraph 1, 5 or 6 of subsection 27 (2); or

(e) assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27 (2).

Counselling

(2) Subsection 27 (1) does not apply with respect to a communication made in the course of counselling about emotional, social, educational or spiritual matters as long as it is not a communication that a health profession Act authorizes members to make. 1991, c. 18, s. 29.

Sexual orientation and gender identity treatments

29.1 (1) No person shall, in the course of providing health care services, provide any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age. 2015, c. 18, s. 2.

Exception

(2) The treatments mentioned in subsection (1) do not include,

(a) services that provide acceptance, support or understanding of a person or the facilitation of a person's coping, social support or identity exploration or development; and

(b) sex-reassignment surgery or any services related to sex-reassignment surgery. 2015, c. 18, s. 2.

Person may consent

(3) Subsection (1) does not apply if the person is capable with respect to the treatment and consents to the provision of the treatment. 2015, c. 18, s. 2.

Substitute decision-maker cannot consent

(4) Despite the *Health Care Consent Act, 1996,* a substitute decision-maker may not give consent on a person's behalf to the provision of any treatment described in subsection (1). 2015, c. 18, s. 2.

Regulations

(5) Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations,

(a) clarifying the meaning of "sexual orientation", "gender identity" or "seek to change" for the purposes of subsection (1);

(b) exempting any person or treatment from the application of subsection (1). 2015, c. 18, s. 2.

Section Amendments with date in force (d/m/y)

2015, c. 18, s. 2 - 04/06/2015

Treatment, etc., where risk of harm

30 (1) No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious bodily harm may result from

the treatment or advice or from an omission from them. 1991, c. 18, s. 30 (1); 2007, c. 10, Sched. M, s. 6.

Exception

(2) Subsection (1) does not apply with respect to treatment by a person who is acting under the direction of or in collaboration with a member if the treatment is within the scope of practice of the member's profession. 1991, c. 18, s. 30 (2).

Delegation

(3) Subsection (1) does not apply with respect to an act by a person if the act is a controlled act that was delegated under section 28 to the person by a member authorized by a health profession Act to do the controlled act. 1991, c. 18, s. 30 (3).

Counselling

(4) Subsection (1) does not apply with respect to counselling about emotional, social, educational or spiritual matters. 1991, c. 18, s. 30 (4).

Exceptions

(5) Subsection (1) does not apply with respect to anything done by a person in the course of,

(a) rendering first aid or temporary assistance in an emergency;

(b) fulfilling the requirements to become a member of a health profession if the person is acting within the scope of practice of the profession under the supervision or direction of a member of the profession;

(c) treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;

(d) treating a member of the person's household; or

(e) assisting a person with his or her routine activities of living. 1991, c. 18, s. 30 (5).

Exemption

(6) Subsection (1) does not apply with respect to an activity or person that is exempted by the regulations. 1991, c. 18, s. 30 (6).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 6 - 04/06/2009

Dispensing hearing aids

31 No person shall dispense a hearing aid for a hearing impaired person except under a prescription by a member authorized by a health profession Act to prescribe a hearing aid for a hearing impaired person. 1991, c. 18, s. 31.

Dental devices, etc.

32 (1) No person shall design, construct, repair or alter a dental prosthetic, restorative or orthodontic device unless,

(a) the technical aspects of the design, construction, repair or alteration are supervised by a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario; or

(b) the person is a member of a College mentioned in clause (a).

Employers

(2) A person who employs a person to design, construct, repair or alter a dental prosthetic, restorative or orthodontic device shall ensure that subsection (1) is complied with.

Supervisors

(3) No person shall supervise the technical aspects of the design, construction, repair or alteration of a dental prosthetic, restorative or orthodontic device unless he or she is a member

of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario.

Denturists

(4) This section does not apply with respect to the design, construction, repair or alteration of removable dentures for the patients of a member of the College of Denturists of Ontario if the member does the designing, construction, repair or alteration or supervises their technical aspects.

Exceptions

(5) This section does not apply with respect to anything done in a hospital as defined in the *Public Hospitals Act* or in a clinic associated with a university's faculty of dentistry or the denturism program of a college of applied arts and technology. 1991, c. 18, s. 32.

Restriction of title "doctor"

33 (1) Except as allowed in the regulations under this Act, no person shall use the title "doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals. 1991, c. 18, s. 33 (1).

Same

(1.1) Subsection (1) does not apply to a person who is a member of the College of Naturopaths of Ontario. 2007, c. 10, Sched. P, s. 20 (1).

Naturopathic doctor

(1.2) A member referred to in subsection (1.1) shall not use the title "doctor" in written format without using the phrase, "naturopathic doctor", immediately following his or her name. 2007, c. 10, Sched. P, s. 20 (1).

Idem

(2) Subsection (1) does not apply to a person who is a member of,

(a) the College of Chiropractors of Ontario;

(b) the College of Optometrists of Ontario;

(c) the College of Physicians and Surgeons of Ontario;

(d) the College of Psychologists of Ontario; or

(e) the Royal College of Dental Surgeons of Ontario. 1991, c. 18, s. 33 (2).

Same

(2.1) Subsection (1) does not apply to a person who is a member of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario and who holds a certificate of registration that entitles the member to use the title "doctor". 2006, c. 27, s. 18 (1).

Definition

(3) In this section,

"abbreviation" includes an abbreviation of a variation. 1991, c. 18, s. 33 (3).

Section Amendments with date in force (d/m/y)

2006, c. 27, s. 18 (1) - 30/12/2016

2007, c. 10, Sched. P, s. 20 (1) - 01/07/2015

Psychotherapist title

33.1 (1) Despite section 8 of the *Psychotherapy Act, 2007*, a person who holds a certificate of registration authorizing him or her to perform the controlled act of psychotherapy and is a member of one of the following Colleges may use the title "psychotherapist" if he or she complies with the conditions in subsections (2), (3) and (4):

1. The College of Nurses of Ontario.

2. The College of Occupational Therapists of Ontario.
3. The College of Physicians and Surgeons of Ontario.
4. The College of Psychologists of Ontario. 2009, c. 26, s. 24 (6).

Oral identification

(2) A person mentioned in subsection (1) shall not describe himself or herself orally as a "psychotherapist" to any person unless the member also mentions the full name of the College where he or she is a member and identifies himself or herself as a member of that College or identifies himself or herself using the title restricted to those who are members of the health profession to which the member belongs. 2009, c. 26, s. 24 (6).

Written identification

(3) A person mentioned in subsection (1) shall not use the title "psychotherapist" in writing in a way that identifies the member as a psychotherapist on a name tag, business card or any document, unless the member sets out his or her full name in writing, immediately followed by at least one of the following, followed in turn by "psychotherapist":

1. The full name of the College where he or she is a member.
2. The name of the health profession that the member practises.
3. The restricted title that the member may use under the health profession Act governing the member's profession. 2009, c. 26, s. 24 (6).

In accordance with regulations

(4) A person mentioned in subsection (1) shall use the title "psychotherapist" in accordance with the regulations made under subsection (5). 2009, c. 26, s. 24 (6).

Regulations

(5) Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council of a College mentioned in paragraphs 1 to 4 of subsection (1) may make regulations governing the use of title "psychotherapist" by members of the College. 2009, c. 26, s. 24 (6).

Section Amendments with date in force (d/m/y)

2009, c. 26, s. 24 (6) - 30/12/2017

Holding out as a College

34 (1) No corporation shall falsely hold itself out as a body that regulates, under statutory authority, individuals who provide health care.

Idem

(2) No individual shall hold himself or herself out as a member, employee or agent of a body that the individual falsely represents as or knows is falsely represented as regulating, under statutory authority, individuals who provide health care. 1991, c. 18, s. 34.

Holding out as a health profession corporation

34.1 (1) No corporation shall hold itself out as a health profession corporation unless it holds a valid certificate of authorization. 2000, c. 42, Sched., s. 30.

Same

(2) No person shall hold himself or herself out as a shareholder, officer, director, agent or employee of a health profession corporation unless the corporation holds a valid certificate of authorization. 2000, c. 42, Sched., s. 30.

Section Amendments with date in force (d/m/y)

2000, c. 42, Sched., s. 30 - 01/11/2001

Exemption, aboriginal healers and midwives

35 (1) This Act does not apply to,

(a) aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community; or

(b) aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community.

Jurisdictions of Colleges

(2) Despite subsection (1), an aboriginal healer or aboriginal midwife who is a member of a College is subject to the jurisdiction of the College.

Definitions

(3) In this section,

"aboriginal healer" means an aboriginal person who provides traditional healing services; ("guérisseur autochtone")

"aboriginal midwife" means an aboriginal person who provides traditional midwifery services. ("sage-femme autochtone") 1991, c. 18, s. 35.

Confidentiality

36 (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every member of a Council or committee of a College shall keep confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

(a) to the extent that the information is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*;

(b) in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;

(c) to a body that governs a profession inside or outside of Ontario;

(d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Health Protection and Promotion Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Long-Term Care Homes Act, 2007*, the *Retirement Homes Act, 2010*, the *Ontario Drug Benefit Act*, the *Coroners Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the Act is amended by striking out "the *Healing Arts Radiation Protection Act*". (See: 2017, c. 25, Sched. 9, s. 115 (1))

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the Act is amended by striking out "the *Independent Health Facilities Act*". (See: 2017, c. 25, Sched. 9, s. 115 (2))

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the Act is amended by adding "the *Oversight of Health Facilities and Devices Act, 2017*" after "the *Long-Term Care Homes Act, 2007*". (See: 2017, c. 25, Sched. 9, s. 115 (3))

(d.1) for a prescribed purpose, to a public hospital that employs or provides privileges to a member of a College, where the College is investigating a complaint about that member or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in regulations made under section 43;

(d.2) for a prescribed purpose, to a person other than a public hospital who belongs to a class provided for in regulations made under section 43, where a College is investigating a complaint about a member of the College or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in the regulations;

(e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;

(f) to the counsel of the person who is required to keep the information confidential under this section;

(g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;

(h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;

(i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons;

(j) with the written consent of the person to whom the information relates; or

(k) to the Minister in order to allow the Minister to determine,

(i) whether the College is fulfilling its duties and carrying out its objects under this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or the *Drug Interchangeability and Dispensing Fee Act*, or

(ii) whether the Minister should exercise any power of the Minister under this Act, or any Act mentioned in subclause (i). 2007, c. 10, Sched. M, s. 7 (1); 2014, c. 14, Sched. 2, s. 10; 2017, c. 11, Sched. 5, s. 2 (1, 2).

Reports required under Code

(1.1) Clauses (1) (c) and (d) do not apply with respect to reports required under section 85.1 or 85.2 of the Code. 1993, c. 37, s. 1. 1998, c. 18, Sched. G, s. 7 (2).

Definition

(1.2) In clause (1) (e),

"law enforcement proceeding" means a proceeding in a court or tribunal that could result in a penalty or sanction being imposed. 1998, c. 18, Sched. G, s. 7 (2); 2007, c. 10, Sched. M, s. 7 (2).

Limitation

(1.3) No person or member described in subsection (1) shall disclose, under clause (1) (e), any information with respect to a person other than a member. 1998, c. 18, Sched. G, s. 7 (2); 2007, c. 10, Sched. M, s. 7 (3).

No requirement

(1.4) Nothing in clause (1) (e) shall require a person described in subsection (1) to disclose information to a police officer unless the information is required to be produced under a warrant. 1998, c. 18, Sched. G, s. 7 (2); 2007, c. 10, Sched. M, s. 7 (4).

Confirmation of investigation

(1.5) Information disclosed under clause (l) (g) shall be limited to the fact that an investigation is or is not underway and shall not include any other information. 2007, c. 10, Sched. M, s. 7 (5).

Restriction

(1.6) Information disclosed to the Minister under clause (1) (k) shall only be used or disclosed for the purpose for which it was provided to the Minister or for a consistent purpose. 2017, c. 11, Sched. 5, s. 2 (3).

Not compellable

(2) No person or member described in subsection (1) shall be compelled to give testimony in a civil proceeding with regard to matters that come to his or her knowledge in the course of his or her duties. 1991, c. 18, s. 36 (2).

Evidence in civil proceedings

(3) No record of a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, no report, document or thing prepared for or statement given at such a proceeding and no order or decision made in such a proceeding is admissible in a civil proceeding other than a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*. 1991, c. 18, s. 36 (3); 1996, c. 1, Sched. G, s. 27 (2).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 1 - 31/12/1993; 1996, c. 1, Sched. G, s. 27 (2) - 27/05/1996; 1998, c. 18, Sched. G, s. 7 (1, 2) - 01/02/1999

2007, c. 10, Sched. M, s. 7 (1-5) - 04/06/2007

2014, c. 14, Sched. 2, s. 10 - 01/08/2016

2017, c. 11, Sched. 5, s. 2 (1-3) - 30/05/2017

2017, c. 25, Sched. 9, s. 115 (1-3) - not in force

Collection of personal information by College

36.1 (1) At the request of the Minister, a College shall collect information directly from members of the College as is reasonably necessary for the purpose of health human resources planning or research. 2017, c. 11, Sched. 5, s. 3 (1).

Unique identifiers

(2) A unique identifier shall be assigned by the Minister or a person designated by the Minister for each member of a College from whom information is collected under subsection (1). 2009, c. 26, s. 24 (7).

Form and manner

(2.1) The unique identifier shall be in the form and manner specified by the Minister. 2009, c. 26, s. 24 (7).

Members to provide information

(3) A member of a College who receives a request for information for the purpose of subsection (1) shall provide the information to the College within the time period and in the form and manner specified by the College. 2007, c. 10, Sched. M, s. 8.

Disclosure to Minister

(4) A College shall disclose the information collected under subsection (1) to the Minister within the time period and in the form and manner specified by the Minister. 2007, c. 10, Sched. M, s. 8.

Use, collection, disclosure and publication

(5) The following applies to information collected under subsection (1):

1. The information may only be used for the purposes set out under subsection (1).
2. The Minister shall not collect personal information if other information will serve the purposes set out under subsection (1).
3. The Minister shall not collect more personal information than is necessary for the purposes set out under subsection (1).
4. The Minister may disclose the information only for the purposes set out in subsection (1).
5. Reports and other documents using information collected under this section may be published for the purposes set out under subsection (1), and for those purposes only, but

personal information about a member of a College shall not be included in those reports or documents. 2017, c. 11, Sched. 5, s. 3 (2).

(6) REPEALED: 2017, c. 11, Sched. 5, s. 3 (2).

Notice required by s. 39 (2) of FIPPA

(7) If the Minister requires a College to collect personal information from its members under subsection (1), the notice required by subsection 39 (2) of the *Freedom of Information and Protection of Privacy Act* is given by,

(a) a public notice posted on the Ministry's website; or

(b) any other public method that may be prescribed. 2007, c. 10, Sched. M, s. 8.

Same

(8) If the Minister publishes a notice referred to under subsection (7), the Minister shall advise the College of the notice and the College shall also publish a notice about the collection on the College's website within 20 days of receiving the advice from the Minister. 2007, c. 10, Sched. M, s. 8.

Definitions

(9) In this section,

"health human resources planning" means ensuring the sufficiency and appropriate distribution of health providers; ("planification des ressources humaines en santé")

"information" includes personal information about members, but does not include personal health information; ("renseignements")

"Ministry" means the Ministry of Health and Long-Term Care; ("ministère")

"research" means the study of data and information in respect of health human resources planning. ("recherche") 2007, c. 10, Sched. M, s. 8; 2017, c. 11, Sched. 5, s. 3 (3, 4).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 8 - 04/06/2007

2009, c. 26, s. 24 (7) - 15/12/2009

2017, c. 11, Sched. 5, s. 3 (1-4) - 30/05/2017

Electronic health record

36.2 (1) The Minister may make regulations,

(a) requiring one or more Colleges to collect from their members information relating to their members that is specified in those regulations and that is, in the Minister's opinion, necessary for the purpose of developing or maintaining the electronic health record under Part V.1 of the *Personal Health Information Protection Act, 2004*, including ensuring that members are accurately identified for purposes of the electronic health record;

(b) requiring the College or Colleges to provide the information to the prescribed organization in the form, manner and timeframe specified by the prescribed organization;

(c) respecting the notice mentioned in subsection (4). 2016, c. 6, Sched. 1, s. 4.

Members to provide information

(2) Where the Minister has made a regulation under subsection (1), and a College has requested information from a member in compliance with the regulation, the member shall comply with the College's request. 2016, c. 6, Sched. 1, s. 4.

Use and disclosure by prescribed organization

(3) Despite a regulation made under subsection (1), the prescribed organization,

(a) may only collect, use or disclose information under this section for the purpose provided for in subsection (1);

(b) shall not use or disclose personal information collected under this section if other information will serve the purpose; and

(c) shall not use or disclose more personal information collected under this section than is necessary for the purpose. 2016, c. 6, Sched. 1, s. 4.

Notice required by s. 39 (2) of *FIPPA*

(4) Where the Minister has made a regulation under subsection (1), and a College is required to collect personal information from its members, the notice required by subsection 39 (2) of the *Freedom of Information and Protection of Privacy Act* is given by,

(a) a public notice posted on the prescribed organization's website; or

(b) any other public method that may be prescribed in regulations made by the Minister under subsection (1). 2016, c. 6, Sched. 1, s. 4.

Same

(5) If the prescribed organization publishes a notice referred to under subsection (4), the prescribed organization shall advise the College of the notice and the College shall also publish a notice about the collection on the College's website within 20 days. 2016, c. 6, Sched. 1, s. 4.

Definitions

(6) In this section,

"information" includes personal information, but does not include personal health information; ("renseignements")

"prescribed organization" has the same meaning as in section 2 of the *Personal Health Information Protection Act, 2004*. ("organisation prescrite") 2016, c. 6, Sched. 1, s. 4; 2017, c. 11, Sched. 5, s. 4.

Section Amendments with date in force (d/m/y)

2016, c. 6, Sched. 1, s. 4 - 03/06/2016

2017, c. 11, Sched. 5, s. 4 - 30/05/2017

Onus of proof to show registration

37 (1) A person who is charged with an offence to which registration under a health profession Act would be a defence shall be deemed, in the absence of evidence to the contrary, to have not been registered. 1991, c. 18, s. 37.

Onus of proof to show certificate of authorization

(2) A person who is charged with an offence to which holding a certificate of authorization would be a defence shall be deemed, in the absence of evidence to the contrary, to have not been issued a certificate of authorization. 2000, c. 42, Sched., s. 31; 2007, c. 10, Sched. M, s. 9 (1).

Injunctions

(3) Subsections (1) and (2) apply, with necessary modifications, to a person who is the subject of an application under section 87 of the Code. 2007, c. 10, Sched. M, s. 9 (2).

Section Amendments with date in force (d/m/y)

2000, c. 42, Sched., s. 31 - 01/11/2001

2007, c. 10, Sched. M, s. 9 (1, 2) - 04/06/2009

Immunity

38 No action or other proceeding for damages shall be instituted against the Crown, the Minister, a College supervisor appointed under section 5.0.1 or his or her staff, an employee of the Crown, the Advisory Council, a College, a Council, or a member, officer, employee, agent or appointee of the Advisory Council, a College, a Council, a committee of a Council or a panel of a committee of a Council for an act done in good faith in the performance or intended

performance of a duty or in the exercise or the intended exercise of a power under this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or a regulation or a by-law under those Acts or for any neglect or default in the performance or exercise in good faith of the duty or power. 1991, c. 18, s. 38; 1998, c. 18, Sched. G, s. 8; 2007, c. 10, Sched. M, s. 10; 2009, c. 26, s. 24 (8).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 8 - 01/02/1999

2007, c. 10, Sched. M, s. 10 - 04/06/2007

2009, c. 26, s. 24 (8) - 15/12/2009

Service

39 (1) A notice or decision to be given to a person under this Act, the *Drug and Pharmacies Regulation Act* or a health profession Act may be given by mail or by fax. 2007, c. 10, Sched. M, s. 11.

When notice or decision given by mail received

(2) If a notice or decision is sent by mail addressed to a person at the person's last known address, there is a rebuttable presumption that it was received by the person on the fifth day after mailing. 2007, c. 10, Sched. M, s. 11.

When notice or decision given by fax received

(3) If a notice or decision is sent by fax to a person at the person's last known fax number, there is a rebuttable presumption that it was received by the person,

(a) on the day it was faxed, if faxed after midnight and before 4 p.m.; or

(b) on the following day, if faxed at any other time. 2007, c. 10, Sched. M, s. 11.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 11 - 04/06/2007

Offences

40 (1) Every person who contravenes subsection 27 (1), 29.1 (1) or 30 (1) is guilty of an offence and on conviction is liable,

(a) for a first offence, to a fine of not more than $25,000, or to imprisonment for a term of not more than one year, or both; and

(b) for a second or subsequent offence, to a fine of not more than $50,000, or to imprisonment for a term of not more than one year, or both. 2007, c. 10, Sched. M, s. 12; 2015, c. 18, s. 3.

Same

(2) Every individual who contravenes section 31, 32 or 33 or subsection 34 (2), 34.1 (2) or 36 (1) is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 12.

Same

(3) Every corporation that contravenes section 31, 32 or 33 or subsection 34 (1), 34.1 (1) or 36 (1) is guilty of an offence and on conviction is liable to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 12.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 2 - 31/12/1993

2000, c. 42, Sched., s. 32 (1, 2) - 01/11/2001

2001, c. 8, s. 217 - 01/11/2001

2007, c. 10, Sched. M, s. 12 - 04/06/2007

2015, c. 18, s. 3 - 06/04/2015

Responsibility of employment agencies

41 Every person who procures employment for an individual and who knows that the individual cannot perform the duties of the position without contravening subsection 27 (1) is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence, and not more than $50,000 for a second or subsequent offence. 1991, c. 18, s. 41; 2007, c. 10, Sched. M, s. 13.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 13 - 04/06/2007

Responsibility of employers

42 (1) The employer of a person who contravenes subsection 27 (1) while acting within the scope of his or her employment is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence, and not more than $50,000 for a second or subsequent offence. 1991, c. 18, s. 42 (1); 2007, c. 10, Sched. M, s. 14 (1).

Responsibility of directors of corporate employers

(2) In addition, if the employer described in subsection (1) is a corporation, every director of the corporation who approved of, permitted or acquiesced in the contravention is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence, and not more than $50,000 for a second or subsequent offence. 1991, c. 18, s. 42 (2); 2007, c. 10, Sched. M, s. 14 (2).

Exception

(3) Subsection (2) does not apply with respect to a corporation that operates a public hospital within the meaning of the *Public Hospitals Act* or to a corporation to which Part III of the *Corporations Act* applies. 1991, c. 18, s. 42 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (3) is amended by striking out "Part III of the *Corporations Act*" and substituting "the *Not-for-Profit Corporations Act, 2010*". See: 2010, c. 15, ss. 241 (1), 249.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 14 (1, 2) - 04/06/2007

2010, c. 15, s. 241 (1) - not in force

No limitation

42.1 Section 76 of the *Provincial Offences Act* does not apply to a prosecution under this Act, the *Drug and Pharmacies Regulation Act* or a health profession Act. 2007, c. 10, Sched. M, s. 15.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 15 - 04/06/2007

Regulations

43 (1) Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations,

(a) prescribing forms of energy for the purposes of paragraph 7 of subsection 27 (2);

(b) exempting a person or activity from subsection 27 (1) or 30 (1);

(c) attaching conditions to an exemption in a regulation made under clause (b);

(d) allowing the use of the title "doctor", a variation or abbreviation or an equivalent in another language;

(e) respecting health profession corporations;

(f) governing the issue, renewal, suspension, revocation and expiration of certificates of authorization;

(g) governing the names of health profession corporations;

(g.1) prescribing purposes and providing for limitations for the purposes of clauses 36 (1) (d.1) and (d.2);

(g.2) providing for classes of persons for the purposes of clause 36 (1) (d.2);

(h) specifying in greater detail the things that shall be provided by or performed by a College under sections 15 to 22.11 of the Code;

(h.0.1) requiring that decisions made under subsections 15 (1) and (4), 18 (2) and (4) and 19 (6) and (8) of the Code be made within a reasonable time;

(h.0.2) requiring that notices required under subsections 15 (3) and 20 (1) of the Code and written reasons required under subsection 20 (1) of the Code be provided within a reasonable time;

(h.1) for the purposes of clause 36.1 (7) (b), prescribing alternative methods of giving the notice required by subsection 39 (2) of the *Freedom of Information and Protection of Privacy Act*;

Note: Clause (h.1) was enacted as clause (h) in the source law, the Statutes of Ontario, 2007, chapter 10, Schedule M, subsection 16 (1). The clause is renumbered in this consolidation to distinguish it from existing clause (h), enacted by the Statutes of Ontario, 2006, chapter 31, subsection 35 (2).

(h.2) prescribing information as information that is to be posted on a College website for the purposes of section 3.1 of the Code;

Note: Clause (h.2) was enacted as clause (i) in the source law, the Statutes of Ontario, 2007, chapter 10, Schedule M, subsection 16 (2). The clause is renumbered in this consolidation to distinguish it from existing clause (i), enacted by the Statutes of Ontario, 2006, chapter 31, subsection 35 (2).

(i) governing reports and certificates to be provided to the Fairness Commissioner, appointed under the *Fair Access to Regulated Professions and Compulsory Trades Act, 2006*, including their form, their manner of preparation, making them available to the public and requiring a College to provide such reports and certificates;

(j) governing other information to be provided to the Fairness Commissioner and requiring persons to provide that information;

(k) governing audits, including specifying audit standards and the scope of audits;

(l) prescribing a longer period in respect of a College for the purpose of section 22.23 of the Code;

(m) defining, for the purposes of sections 22.3 and 22.15 to 22.23 of the Code, any word or expression that is used in those sections but not defined in this Act;

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by adding the following clause:

(n) prescribing for the purposes of subsection 2 (2) of the Code, the provisions of the *Not-for-Profit Corporations Act, 2010* that apply to a College.

See: 2010, c. 15, ss. 241 (2), 249.

(o) establishing criteria for the definition of “patient” in relation to professional misconduct involving the sexual abuse of a patient for the purposes of subsection 1 (3) of the Code.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 43 (1) of the Act is amended by adding the following clauses: (See: 2017, c. 11, Sched. 5, s. 5 (2))

(p) respecting the composition of committees that a College is required to have pursuant to subsection 10 (1) of the Code and governing the relationship between such regulations and the by-laws of the College;

(q) respecting the qualification, selection, appointment and terms of office of members of committees that a College is required to have pursuant to subsection 10 (1) of the Code and governing the relationship between such regulations and the by-laws of the College;

(r) prescribing conditions that disqualify committee members from sitting on committees that a College is required to have pursuant to subsection 10 (1) of the Code and governing the removal of disqualified committee members and governing the relationship between such regulations and the by-laws of the College;

(s) specifying the composition of panels selected from amongst the members of the Registration Committee, Inquiries, Complaints and Reports Committee, Discipline Committee and Fitness to Practise Committee for the purposes of subsections 17 (2), 25 (2), 38 (2) and 64 (2) of the Code, and providing for quorum for such panels.

(t) prescribing additional information to be contained in a College's register for the purposes of paragraph 19 of subsection 23 (2) of the Code and designating such information as information subject to subsection 23 (13.1) of the Code;

(u) prescribing conduct for the purposes of subparagraph 3 vii of subsection 51 (5) of the Code;

(v) prescribing offences for the purposes of clause 51 (5.2) (a) of the Code.

(w) clarifying how a College is required to perform its functions under sections 25 to 69 and 72 to 74 of the Code with respect to matters involving allegations of a member's misconduct of a sexual nature, and providing for further functions and duties that are not inconsistent with those functions.

(x) prescribing additional functions of the patient relations program for the purposes of subsection 84 (3.1) of the Code.

(y) prescribing additional purposes for which funding may be provided under the program which Colleges are required to maintain under section 85.7 of the Code, and prescribing additional persons or classes of persons to whom funding may be paid for the purposes of subsection 85.7 (8) of the Code.

(z) governing transitional matters arising from the enactment of Schedule 5 to the *Protecting Patients Act, 2017*. 1991, c. 18, s. 43 (1); 2000, c. 42, Sched., s. 33; 2006, c. 31, s. 35 (2); 2007, c. 10, Sched. M, s. 16; 2009, c. 24, s. 33 (2); 2014, c. 14, Sched. 2, s. 11; 2015, c. 8, s. 38 (1); 2017, c. 2, Sched. 9, s. 10; 2017, c. 11, Sched. 5, s. 5 (1, 3-8).

Scope of regulations

(2) A regulation may be general or particular in its application. 1991, c. 18, s. 43 (2).

Definition

(3) In clause (1) (d),

"abbreviation" includes an abbreviation of a variation. 1991, c. 18, s. 43 (3).

Section Amendments with date in force (d/m/y)

2000, c. 42, Sched., s. 33 - 01/11/2001

2006, c. 31, s. 35 (2) - 01/03/2007

2007, c. 10, Sched. M, s. 16 (1) - 04/06/2007; 2007, c. 10, Sched. M, s. 16 (2) - 04/06/2009

2009, c. 24, s. 33 (2) - 15/12/2009

2010, c. 15, s. 241 (2) - not in force

2014, c. 14, Sched. 2, s. 11 - 01/08/2016

2015, c. 8, s. 38 (1) - 01/01/2018

2017, c. 2, Sched. 9, s. 10 - 22/03/2017; 2017, c. 11, Sched. 5, s. 5 (1, 7) - 01/05/2018; 2017, c. 11, Sched. 5, s. 5 (2) - not in force; 2017, c. 11, Sched. 5, s. 5 (3-6, 8) - 30/05/2017

Regulations

43.1 Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations governing funding under programs required under section 85.7 of the Code, including regulations,

(a) prescribing the maximum amount or a means of establishing the maximum amount of funding that may be provided for a person in respect of a case of sexual abuse;

(b) prescribing the period of time during which funding may be provided for a person in respect of a case of sexual abuse. 1993, c. 37, s. 3.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 3 - 31/12/1993

Expert committees

43.2 The Lieutenant Governor in Council may make regulations,

(a) establishing one or more expert committees for the purposes of this Act, the Code and health profession Acts;

(b) specifying the functions, duties, powers and membership of an expert committee;

(c) requiring an expert committee to provide reports and information to the Minister and providing for the content of such reports and information;

(d) requiring information to be provided by a College or Council to an expert committee, and governing the content of the information and the form and manner and time within which the information is to be provided to the committee. 2009, c. 26, s. 24 (9).

Section Amendments with date in force (d/m/y)

2009, c. 26, s. 24 (9) - 15/12/2009

References to health professionals

44 A reference in an Act or regulation to a person described in Column 1 of the Table shall be deemed to be a reference to a person described opposite in Column 2. 1991, c. 18, s. 44.

45 OMITTED (AMENDS OR REPEALS OTHER ACTS). 1991, c. 18, s. 45.

46 OMITTED (REVOKES REGULATIONS). 1991, c. 18, s. 46.

47, 48 OMITTED (AMENDS OR REPEALS OTHER ACTS). 1991, c. 18, ss. 47, 48.

49 OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS ACT). 1991, c. 18, s. 49.

50 OMITTED (ENACTS SHORT TITLE OF THIS ACT). 1991, c. 18, s. 50.

TABLE

Item	Column 1	Column 2
1.	person registered as a chiropodist under the *Chiropody Act*	member of the College of Chiropodists of Ontario
2.	person registered as a dental technician under the *Dental Technicians Act*	member of the College of Dental Technologists of Ontario
3.	person licensed as a denture therapist under the *Denture Therapists Act*	member of the College of Denturists of Ontario
4.	person registered as a chiropractor under the *Drugless Practitioners Act*	member of the College of Chiropractors of Ontario
5.	person registered as a masseur under the *Drugless Practitioners Act*	member of the College of Massage Therapists of Ontario
6.	REPEALED. See: Table of Public Statute Provisions Repealed Under Section 10.1 of the *Legislation Act, 2006* – December 31, 2011.	
7.	person registered as a physiotherapist under the *Drugless Practitioners Act*	member of the College of Physiotherapists of Ontario
7.1	person registered under the *Drugless Practitioners Act*	member of the College of Naturopaths of Ontario
8.	person registered as a dental hygienist	member of the College of Dental Hygienists

	under Part II of the *Health Disciplines Act*	of Ontario
9.	person licensed under Part II of the *Health Disciplines Act*	member of the Royal College of Dental Surgeons of Ontario
10.	person licensed under Part III of the *Health Disciplines Act*	member of the College of Physicians and Surgeons of Ontario
11.	person who is the holder of a certificate issued under Part IV of the *Health Disciplines Act*	member of the College of Nurses of Ontario
12.	person licensed under Part V of the *Health Disciplines Act*	member of the College of Optometrists of Ontario
13.	person licensed under Part VI of the *Health Disciplines Act*	member of the Ontario College of Pharmacists
14.	Person registered under the *Ophthalmic Dispensers Act*	member of the College of Opticians of Ontario
15.	person registered under the *Psychologists Registration Act*	member of the College of Psychologists of Ontario
16.	person registered under the *Radiological Technicians Act*	member of the College of Medical Radiation Technologists of Ontario

1991, c. 18, Table; See: Table of Public Statute Provisions Repealed Under Section 10.1 of the *Legislation Act, 2006* – December 31, 2011; 2007, c. 10, Sched. P, s. 20 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, item 16 of the Table to the Act is struck out and the following substituted: (See: 2017, c. 25, Sched. 6, s. 17 (1))

16.	person registered under the *Radiological Technicians Act*	member of the College of Medical Radiation and Imaging Technologists of Ontario
17.	member of the College of Medical Radiation Technologists of Ontario	member of the College of Medical Radiation and Imaging Technologists of Ontario

Section Amendments with date in force (d/m/y)

Table of Public Statute Provisions Repealed Under Section 10.1 of the *Legislation Act, 2006* - 31/12/2011

2007, c. 10, Sched. P, s. 20 (2) - 01/07/2015

2017, c. 25, Sched. 9, s. 17 (1) - not in force

SCHEDULE 1

SELF GOVERNING HEALTH PROFESSIONS

Health Profession Acts	*Health Profession*
Audiology and Speech-Language Pathology Act, 1991	Audiology and Speech-Language Pathology
Chiropody Act, 1991	Chiropody
Chiropractic Act, 1991	Chiropractic
Dental Hygiene Act, 1991	Dental Hygiene
Dental Technology Act, 1991	Dental Technology
Dentistry Act, 1991	Dentistry
Denturism Act, 1991	Denturism
Dietetics Act, 1991	Dietetics
Homeopathy Act, 2007	Homeopathy
Kinesiology Act, 2007	Kinesiology
Massage Therapy Act, 1991	Massage Therapy
Medical Laboratory Technology Act, 1991	Medical Laboratory Technology
Medical Radiation Technology Act, 1991	Medical Radiation Technology
Medicine Act, 1991	Medicine
Midwifery Act, 1991	Midwifery
Naturopathy Act, 2007	Naturopathy
Nursing Act, 1991	Nursing
Occupational Therapy Act, 1991	Occupational Therapy
Opticianry Act, 1991	Opticianry
Optometry Act, 1991	Optometry

Pharmacy Act, 1991	Pharmacy
Physiotherapy Act, 1991	Physiotherapy
Psychology Act, 1991	Psychology
Psychotherapy Act, 2007	Psychotherapy
Respiratory Therapy Act, 1991	Respiratory Therapy
Traditional Chinese Medicine Act, 2006	Traditional Chinese Medicine

1991, c. 18, Sched. 1; 1998, c. 18, Sched. G, s. 9; 2006, c. 27, s. 18 (2); 2007, c. 10, Sched. O, s. 14; 2007, c. 10, Sched. Q, s. 14; 2007, c. 10, Sched. R, s. 19 (3); 2007, c. 10, Sched. P, s. 20 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, Schedule 1 to the Act is amended by striking out,

Medical Radiation Technology Act, 1991	**Medical Radiation Technology**

and substituting the following: (See: 2017, c. 25, Sched. 6, s. 17 (2))

Medical Radiation and Imaging Technology Act, 2017	Medical Radiation and Imaging Technology

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 9, 23 (2-4) - 01/02/1999

2006, c. 27, s. 18 (2) - 01/04/2013

2007, c. 10, Sched. O, s. 14 - 01/04/2013; 2007, c. 10, Sched. P, s. 20 (3) - 01/07/2015; 2007, c. 10, Sched. Q, s. 14 - 01/04/2015; 2007, c. 10, Sched. R, s. 19 (3) - 01/04/2015

2017, c. 25, Sched. 9, s. 17 (2) - not in force

SCHEDULE 2

HEALTH PROFESSIONS PROCEDURAL CODE

Note: This Code is deemed by section 4 of the *Regulated Health Professions Act, 1991* to be part of each health profession Act.

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Interpretation

1 (1) In this Code,

"alternative dispute resolution process" means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute; ("processus de règlement extrajudiciaire des différends")

"Board" means the Health Professions Appeal and Review Board under the *Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998*; ("Commission")

"by-laws" means by-laws made by the Council; ("règlements administratifs")

"certificate of authorization" means a certificate of authorization issued under the *Regulated Health Professions Act, 1991* or this Code; ("certificat d'autorisation")

"certificate of registration" means a certificate of registration issued by the Registrar; ("certificat d'inscription")

"Council" means the Council of the College; ("conseil")

"drug" means drug as defined in subsection 117 (1) of the *Drug and Pharmacies Regulation Act*; ("médicament")

"health profession corporation" means a corporation incorporated under the *Business Corporations Act* that holds a valid certificate of authorization issued under the *Regulated Health Professions Act, 1991* or this Code; ("société professionnelle de la santé")

"incapacitated" means, in relation to a member, that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practise; ("frappé d'incapacité")

"member" means a member of the College; ("membre")

"Minister" means the Minister of Health and Long-Term Care; ("ministre")

"patient relations program" means a program to enhance relations between members and patients; ("programme de relations avec les patients")

"prescribed" means prescribed in the regulations; ("prescrit")

"quality assurance program" means a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members; ("programme d'assurance de la qualité")

"Registrar" means the Registrar of the College; ("registrateur")

“registration” means the issuance of a certificate of registration. (“inscription”) 1991, c. 18, Sched. 2, s. 1 (1); 1998, c. 18, Sched. G, s. 10; 2000, c. 42, Sched., s. 34; 2006, c. 19, Sched. L, s. 11 (2); 2007, c. 10, Sched. M, s. 17; 2009, c. 26, s. 24 (10).

Hearing not required unless referred to

(2) Nothing in the health profession Act or this Code shall be construed to require a hearing to be held within the meaning of the *Statutory Powers Procedure Act* unless the holding of a hearing is specifically referred to. 1991, c. 18, Sched. 2, s. 1 (2).

Sexual abuse of a patient

(3) In this Code,

“sexual abuse” of a patient by a member means,

(a) sexual intercourse or other forms of physical sexual relations between the member and the patient,

(b) touching, of a sexual nature, of the patient by the member, or

(c) behaviour or remarks of a sexual nature by the member towards the patient. 1993, c. 37, s. 4.

Exception

(4) For the purposes of subsection (3),

“sexual nature” does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided. 1993, c. 37, s. 4.

Exception, spouses

(5) If the Council has made a regulation under clause 95 (1) (0.a), conduct, behaviour or remarks that would otherwise constitute sexual abuse of a patient by a member under the definition of “sexual abuse” in subsection (3) do not constitute sexual abuse if,

(a) the patient is the member’s spouse; and

(b) the member is not engaged in the practice of the profession at the time the conduct, behaviour or remark occurs. 2013, c. 9, s. 1 (1).

Definitions

(6) For the purposes of subsections (3) and (5),

“patient”, without restricting the ordinary meaning of the term, includes,

(a) an individual who was a member’s patient within one year or such longer period of time as may be prescribed from the date on which the individual ceased to be the member’s patient, and

(b) an individual who is determined to be a patient in accordance with the criteria in any regulations made under clause 43 (1) (o) of the *Regulated Health Professions Act, 1991*; (“patient”)

“spouse”, in relation to a member, means,

(a) a person who is the member’s spouse as defined in section 1 of the *Family Law Act*, or

(b) a person who has lived with the member in a conjugal relationship outside of marriage continuously for a period of not less than three years. (“conjoint”) 2017, c. 11, Sched. 5, s. 6.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 4 - 31/12/1993; 1998, c. 18, Sched. G, s. 10 - 01/02/1999

2000, c. 42, Sched., s. 34 - 01/11/2001

2006, c. 19, Sched. L, s. 11 (2) - 22/06/2006

2007, c. 10, Sched. M, s. 17 (1, 2, 4) - 04/06/2009; 2007, c. 10, Sched. M, s. 17 (3) - 04/06/2007

2009, c. 26, s. 24 (10) - 15/12/2009; 2009, c. 33, Sched. 18, s. 17 (2) - 15/12/2009

2013, c. 9, s. 1 (1) - 06/11/2013

2017, c. 11, Sched. 5, s. 6 - 01/05/2018

Statement of purpose, sexual abuse provisions

1.1 The purpose of the provisions of this Code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling in connection with allegations of sexual abuse by members and, ultimately, to eradicate the sexual abuse of patients by members. 2017, c. 11, Sched. 5, s. 7.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 5 - 31/12/1993

2017, c. 11, Sched. 5, s. 7 - 01/05/2018

COLLEGE

College is body corporate

2 (1) The College is a body corporate without share capital with all the powers of a natural person. 1991, c. 18, Sched. 2, s. 2 (1).

Corporations Act

(2) The *Corporations Act* does not apply in respect to the College. 1991, c. 18, Sched. 2, s. 2 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is repealed and the following substituted:

Not-for-Profit Corporations Act, 2010

(2) The *Not-for-Profit Corporations Act, 2010* does not apply to the College, except as may be prescribed by regulation made under clause 43 (1) (n) of the *Regulated Health Professions Act, 1991*. 2010, c. 15, s. 241 (3).

See: 2010, c. 15, ss. 241 (3), 249.

Section Amendments with date in force (d/m/y)

2010, c. 15, s. 241 (3) - not in force

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

Section Amendments with date in force (d/m/y)

2008, c. 18, s. 1 - 27/11/2008

Objects of College

3 (1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.

4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.

4.1 To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.

5. To develop, establish and maintain standards of professional ethics for the members.

6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.

7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.

8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.

9. To promote inter-professional collaboration with other health profession colleges.

10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 18 - 04/06/2009

2009, c. 26, s. 24 (11) - 15/12/2009

College website

3.1 (1) The College shall have a website, and shall include on its website information as may be prescribed in regulations made under clause 43 (1) (h.2) of the *Regulated Health Professions Act, 1991*. 2007, c. 10, Sched. M, s. 19.

Paper or electronic form

(2) Upon request and, if required by the College, the payment of a reasonable fee, the College shall provide the information required to be posted under subsection (1) in paper or electronic form. 2007, c. 10, Sched. M, s. 19.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 19 - 04/06/2009

Council

4 The College shall have a Council that shall be its board of directors and that shall manage and administer its affairs. 1991, c. 18, Sched. 2, s. 4.

Terms

5 (1) No term of a Council member who is elected shall exceed three years.

Multiple terms

(2) A person may be a Council member for more than one term but no person who is elected may be a Council member for more than nine consecutive years. 1991, c. 18, Sched. 2, s. 5.

Quorum

6 A majority of the members of the Council constitute a quorum. 1991, c. 18, Sched. 2, s. 6.

Meetings

7 (1) The meetings of the Council shall be open to the public and reasonable notice shall be given to the members of the College, to the Minister, and to the public. 2007, c. 10, Sched. M, s. 20 (1).

Posting of meeting information

(1.1) The College shall post on its website information regarding upcoming meetings of the Council, including the dates of those meetings, matters to be discussed at those meetings, and information and documentation that will be provided to members of the Council for the purpose of those meetings. 2017, c. 11, Sched. 5, s. 8.

Items where public excluded

(1.2) If the Registrar anticipates that the Council will exclude the public from any meeting or part of a meeting under subsection (2), the grounds for doing so shall be noted in the information posted under subsection (1.1) and information and documentation related to that meeting or part of that meeting shall not be posted under subsection (1.1). 2017, c. 11, Sched. 5, s. 8.

Exclusion of public

(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(a) matters involving public security may be disclosed;

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;

(c) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced;

(d) personnel matters or property acquisitions will be discussed;

(e) instructions will be given to or opinions received from the solicitors for the College; or

(f) the Council will deliberate whether to exclude the public from a meeting or whether to make an order under subsection (3). 1991, c. 18, Sched. 2, s. 7 (2); 2007, c. 10, Sched. M, s. 20 (2).

Orders preventing public disclosure

(3) In situations in which the Council may exclude the public from meetings, it may make orders it considers necessary to prevent the public disclosure of matters disclosed in the meeting, including banning publication or broadcasting of those matters. 1991, c. 18, Sched. 2, s. 7 (3).

Grounds noted in minutes

(4) If the Council excludes the public from a meeting or makes an order under subsection (3), it shall have its grounds for doing so noted in the minutes of the meeting. 2007, c. 10, Sched. M, s. 20 (3).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 20 (1-3) - 04/06/2009

2017, c. 11, Sched. 5, s. 8 - 30/05/2017

Remuneration and expenses

8 Council members appointed by the Lieutenant Governor in Council shall be paid, by the Minister, the expenses and remuneration the Lieutenant Governor in Council determines. 1991, c. 18, Sched. 2, s. 8; 2006, c. 19, Sched. L, s. 10 (1).

Section Amendments with date in force (d/m/y)

2006, c. 19, Sched. L, s. 10 (1) - 22/06/2006

Employees

9 (1) The Council may employ persons it considers advisable.

Registrar

(2) The Council shall appoint one of its employees as the Registrar. 1991, c. 18, Sched. 2, s. 9.

Committees

10 (1) The College shall have the following committees:

1. Executive Committee.
2. Registration Committee.
3. Inquiries, Complaints and Reports Committee.
4. Discipline Committee.
5. Fitness to Practise Committee.
6. Quality Assurance Committee.
7. Patient Relations Committee. 1991, c. 18, Sched. 2, s. 10 (1); 2007, c. 10, Sched. M, s. 21 (1).

Transitional

(1.1) For greater certainty, where, at the time subsection 21 (1) of Schedule M to the *Health System Improvements Act, 2007* comes into force, any matter that is before the Board based on anything done by the Committee formerly known as the Complaints Committee shall proceed as if the Board had the authority to do anything it could have done before the coming into force of sections 30 to 32 of that Schedule. 2007, c. 10, Sched. M, s. 21 (2).

Same

(1.2) Where a regulation made under the *Regulated Health Professions Act, 1991* or a health profession Act that was made before the coming into force of subsection 21 (1) of Schedule M to the *Health System Improvements Act, 2007* refers to the Complaints Committee, the reference shall be deemed to be to the Inquiries, Complaints and Reports Committee. 2009, c. 26, s. 24 (12).

Appointment

(2) The Council shall appoint the members of the committees. 1991, c. 18, Sched. 2, s. 10 (2).

Composition

(3) The composition of the committees shall be in accordance with the by-laws. 1991, c. 18, Sched. 2, s. 10 (3); 1998, c. 18, Sched. G, s. 11.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 10 (3) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 9)

Composition

(3) The composition of the committees shall be in accordance with the by-laws and with any regulations made pursuant to clauses 43 (1) (p) to (r) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 9.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 11 - 01/02/1999

2007, c. 10, Sched. M, s. 21 (1, 2) - 04/06/2009

2009, c. 26, s. 24 (12) - 15/12/2009

2017, c. 11, Sched. 5, s. 9 - not in force

Annual reports

11 (1) Each committee named in subsection 10 (1) shall monitor and evaluate their processes and outcomes and shall annually submit a report of its activities to the Council in a form acceptable to the Council. 2007, c. 10, Sched. M, s. 22.

Exclusions from reports

(2) The Inquiries, Complaints and Reports Committee shall not submit a report that contains information, other than information of a general statistical nature, relating to,

(a) a referral by the Inquiries, Complaints and Reports Committee to the Discipline or Fitness to Practise Committee until a panel of the Discipline or Fitness to Practise Committee disposes of the matter;

(b) an approval for the Registrar to appoint an investigator until the investigation is completed and reported by the Registrar and the Inquiries, Complaints and Reports Committee decides not to make a referral with respect to the matter to the Discipline Committee or, if the Inquiries, Complaints and Reports Committee makes a referral with respect to the matter to the Discipline Committee, until a panel of the Discipline Committee disposes of the matter; or

(c) an interim order made by the Inquiries, Complaints and Reports Committee in respect of a member until a panel of the Discipline Committee disposes of the matter. 2007, c. 10, Sched. M, s. 22.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 22 - 04/06/2009

Executive Committee's exercise of Council's powers

12 (1) Between the meetings of the Council, the Executive Committee has all the powers of the Council with respect to any matter that, in the Committee's opinion, requires immediate attention, other than the power to make, amend or revoke a regulation or by-law.

Report to Council

(2) If the Executive Committee exercises a power of the Council under subsection (1), it shall report on its actions to the Council at the Council's next meeting. 1991, c. 18, Sched. 2, s. 12.

Members

13 (1) A person registered by the College is a member.

Suspended members

(2) A person whose certificate of registration is suspended is not a member. 1991, c. 18, Sched. 2, s. 13.

Note: On a day to be named by proclamation of the Lieutenant Governor, Schedule 2 is amended by adding the following section:

Professional liability insurance

13.1 (1) No member of a College in Ontario shall engage in the practice of the health profession unless he or she is personally insured against professional liability under a professional liability insurance policy or belongs to a specified association that provides the member with personal protection against professional liability. 2009, c. 26, s. 24 (13).

Insurance requirements

(2) A member mentioned in subsection (1) shall comply with the requirements respecting professional liability insurance or protection against professional liability specified by the College and prescribed in the regulations made under the health profession Act governing the member's health profession or set out in the by-laws. 2009, c. 26, s. 24 (13).

Professional misconduct

(3) In addition to the grounds set out in subsection 51 (1), a panel of the Discipline Committee shall find that a member has committed an act of professional misconduct if the member fails to comply with subsection (1) or (2). 2009, c. 26, s. 24 (13).

See: 2009, c. 26, ss. 24 (13), 27 (2).

Section Amendments with date in force (d/m/y)

2009, c. 26, s. 24 (13) - not in force

Continuing jurisdiction

14 (1) A person whose certificate of registration is revoked or expires or who resigns as a member continues to be subject to the jurisdiction of the College for professional misconduct or incompetence referable to the time when the person was a member and may be investigated under section 75. 2007, c. 10, Sched. M, s. 23 (1).

Idem

(2) A person whose certificate of registration is suspended continues to be subject to the jurisdiction of the College for incapacity and for professional misconduct or incompetence referable to the time when the person was a member or to the period of the suspension and may be investigated under section 75. 1991, c. 18, Sched. 2, s. 14 (2); 2007, c. 10, Sched. M, s. 23 (2).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 23 (1, 2) - 04/06/2009

REGISTRATION

Registration

15 (1) If a person applies to the Registrar for registration, the Registrar shall,

(a) register the applicant; or

(b) refer the application to the Registration Committee. 1991, c. 18, Sched. 2, s. 15 (1).

Referrals to Registration Committee

(2) The Registrar shall refer an application for registration to the Registration Committee if the Registrar,

(a) has doubts, on reasonable grounds, about whether the applicant fulfils the registration requirements;

(a.1) is of the opinion that terms, conditions or limitations should be imposed on a certificate of registration of the applicant and the applicant is an individual described in subsection 22.18 (1);

(b) is of the opinion that terms, conditions or limitations should be imposed on a certificate of registration of the applicant and the applicant does not consent to the imposition; or

(c) proposes to refuse the application. 1991, c. 18, Sched. 2, s. 15 (2); 1993, c. 37, s. 6; 2009, c. 24, s. 33 (3).

Notice to applicant

(3) If the Registrar refers an application to the Registration Committee, he or she shall give the applicant notice of the statutory grounds for the referral and of the applicant's right to make written submissions under subsection 18 (1). 1991, c. 18, Sched. 2, s. 15 (3).

Terms, etc., attached on consent

(4) If the Registrar is of the opinion that a certificate of registration should be issued to an applicant with terms, conditions or limitations imposed and the applicant consents to the imposition, the Registrar may do so with the approval of a panel of the Registration Committee selected by the chair for the purpose. 1991, c. 18, Sched. 2, s. 15 (4).

Panels for consent

(5) Subsections 17 (2) and (3) apply with respect to the panel mentioned in subsection (4). 1991, c. 18, Sched. 2, s. 15 (5).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 6 - 31/12/1993

2009, c. 24, s. 33 (3) - 15/12/2009

Disclosure of application file

16 (1) The Registrar shall give an applicant for registration, at his or her request, all the information and a copy of each document the College has that is relevant to the application.

Exception

(2) The Registrar may refuse to give an applicant anything that may, in the Registrar's opinion, jeopardize the safety of any person. 1991, c. 18, Sched. 2, s. 16.

Process for dealing with request

(3) The Registrar shall establish a process for the purposes of dealing with an applicant's request under subsection (1). 2015, c. 8, s. 38 (2).

Fee for access

(4) The Registrar may require an applicant to pay a fee for making information and documents available to the applicant if the Registrar first gives the applicant an estimate of the fee. 2015, c. 8, s. 38 (2).

Amount of fee

(5) The amount of the fee shall not exceed the amount of reasonable cost recovery. 2015, c. 8, s. 38 (2).

Waiver of fee

(6) The Registrar may waive the payment of all or any part of the fee that an applicant is required to pay under subsection (4) if, in the Registrar's opinion, it is fair and equitable to do so. 2015, c. 8, s. 38 (2).

Section Amendments with date in force (d/m/y)

2015, c. 8, s. 38 (2) - 01/01/2018

Panels

17 (1) An application for registration referred to the Registration Committee or an application referred back to the Registration Committee by the Board shall be considered by a panel selected by the chair from among the members of the Committee. 1991, c. 18, Sched. 2, s. 17 (1); 2007, c. 10, Sched. M, s. 24 (1).

Composition of panels

(2) A panel shall be composed of at least three persons, at least one of whom shall be a person appointed to the Council by the Lieutenant Governor in Council. 2007, c. 10, Sched. M, s. 24 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 17 (2) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 10)

Composition of panels

(2) The panel selected by the chair shall be composed in accordance with regulations made pursuant to clauses 43 (1) (p) to (s) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 10.

Quorum

(3) Three members of a panel constitute a quorum. 1991, c. 18, Sched. 2, s. 17 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 17 (3) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 10)

Quorum

(3) Quorum for the panel shall be in accordance with regulations made pursuant to clause 43 (1) (s) of the Regulated Health *Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 10.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 24 (1, 2) - 04/06/2009

2017, c. 11, Sched. 5, s. 10 - not in force

Consideration by panel

18 (1) An applicant may make written submissions to the panel within thirty days after receiving notice under subsection 15 (3) or within any longer period the Registrar may specify in the notice.

Orders by panel

(2) After considering the application and the submissions, the panel may make an order doing any one or more of the following:

1. Directing the Registrar to issue a certificate of registration.
2. Directing the Registrar to issue a certificate of registration if the applicant successfully completes examinations set or approved by the panel.
3. Directing the Registrar to issue a certificate of registration if the applicant successfully completes additional training specified by the panel.
4. Directing the Registrar to impose specified terms, conditions and limitations on a certificate of registration of the applicant and specifying a limitation on the applicant's right to apply under subsection 19 (1).
5. Directing the Registrar to refuse to issue a certificate of registration.

Idem

(3) A panel, in making an order under subsection (2), may direct the Registrar to issue a certificate of registration to an applicant who does not meet a registration requirement unless the requirement is prescribed as a non-exemptible requirement.

Order on consent

(4) The panel may, with the consent of the applicant, direct the Registrar to issue a certificate of registration with the terms, conditions and limitations specified by the panel imposed. 1991, c. 18, Sched. 2, s. 18.

Application for variation

19 (1) A member may apply to the Registration Committee for an order directing the Registrar to remove or modify any term, condition or limitation imposed on the member's certificate of registration as a result of a registration proceeding. 1991, c. 18, Sched. 2, s. 19 (1).

Limitations

(2) The right to apply under subsection (1) is subject to any limitation in the order imposing the term, condition or limitation or to which the member consented and to any limitation made under subsection (7) in the disposition of a previous application under this section. 1991, c. 18, Sched. 2, s. 19 (2).

Panels

(3) An application to the Registration Committee under subsection (1) or an application referred back to the Registration Committee by the Board shall be considered by a panel selected by the chair from among the members of the Committee. 1991, c. 18, Sched. 2, s. 19 (3); 2007, c. 10, Sched. M, s. 25 (1).

Idem

(4) Subsections 17 (2) and (3) apply with respect to the panel mentioned in subsection (3). 1991, c. 18, Sched. 2, s. 19 (4).

Submissions

(5) An applicant may make written submissions to the panel. 1991, c. 18, Sched. 2, s. 19 (5).

Orders

(6) After considering the application and the submissions, the panel may make an order doing any one or more of the following:

1. Refusing the application.
2. Directing the Registrar to remove any term, condition or limitation imposed on the certificate of registration.
3. Directing the Registrar to modify terms, conditions or limitations on the certificate of registration. 1991, c. 18, Sched. 2, s. 19 (6); 2007, c. 10, Sched. M, s. 25 (2).

Limitations on applications

(7) When an application has been disposed of under this section, the applicant may not make a new application under subsection (1) within six months of the disposition without leave of the Registrar. 2007, c. 10, Sched. M, s. 25 (3).

Registrar's leave

(8) The Registrar may only give leave for a new application to be made under subsection (7) if the Registrar is satisfied that there has been a material change in circumstances that justifies the giving of the leave. 2007, c. 10, Sched. M, s. 25 (3).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 25 (1-3) - 04/06/2009

Notice of orders

20 (1) A panel shall give the applicant notice of an order it makes under subsection 18 (2) or 19 (6) and written reasons for it if the order,

(a) directs the Registrar to refuse to issue a certificate of registration;

(b) directs the Registrar to issue a certificate of registration if the applicant successfully completes examinations or additional training;

(c) directs the Registrar to impose terms, conditions and limitations on a certificate of registration of the applicant; or

(d) refuses an application for an order removing or modifying any term, condition or limitation imposed on a certificate of registration. 1991, c. 18, Sched. 2, s. 20 (1).

Contents of notice

(2) A notice under subsection (1) shall inform the applicant of the order and of the provisions of section 19 and of subsections 21 (1) and (2). 1991, c. 18, Sched. 2, s. 20 (2); 2007, c. 10, Sched. M, s. 26.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 26 - 04/06/2009

Appeal to Board

21 (1) An applicant who has been given a notice under subsection 20 (1) of an order may require the Board to hold a review of the application and the documentary evidence in support of it, or a hearing of the application, by giving the Board and the Registration Committee notice in accordance with subsection (2).

Requirements of notice

(2) A notice under subsection (1) shall be a written notice, given within thirty days after the notice under subsection 20 (1) was given, specifying whether a review or a hearing is required.

Order, etc., to Board

(3) If the Registration Committee receives a notice that an applicant requires a hearing or review, it shall, within fifteen days after receiving the notice, give the Board a copy of the order made with respect to the application, the reasons for it and the documents and things upon which the decision to make the order was based.

When order may be carried out

(4) An order of a panel, notice of which is required under subsection 20 (1), may be carried out only when,

(a) the applicant has given the Registrar notice that the applicant will not be requiring a review or hearing;

(b) thirty-five days have passed since the notice of the order was given under subsection 20 (1) without the applicant requiring a review or hearing; or

(c) the Board has confirmed the order. 1991, c. 18, Sched. 2, s. 21.

Registration hearings or reviews

22 (1) This section applies to a hearing or review by the Board required by an applicant under subsection 21 (1). 1991, c. 18, Sched. 2, s. 22 (1).

Procedural provisions

(2) The following provisions apply with necessary modifications to a hearing or review:

1. Subsection 38 (4) (exclusion from panel).
2. Section 42 (disclosure of evidence).
3. Section 43 (no communication by panel members).
4. Section 50 (members of panel who participate).
5. Section 55 (release of evidence). 1991, c. 18, Sched. 2, s. 22 (2).

Idem

(3) The following provisions also apply with necessary modifications to a hearing:

1. Section 45 (hearings open).
2. Section 47 (sexual misconduct witnesses).
3. Section 48 (transcript of hearings). 1991, c. 18, Sched. 2, s. 22 (3).

Same

(3.1) The following provisions of the *Statutory Powers Procedure Act* also apply with necessary modifications to a review by the Board:

1. Section 21.1 (correction of errors).
2. Section 25.1 (rules). 1998, c. 18, Sched. G, s. 12.

Findings of fact

(4) The findings of fact in a hearing shall be based exclusively on evidence admissible or matters that may be noticed under sections 15, 15.1, 15.2 and 16 of the *Statutory Powers Procedure Act*. 1991, c. 18, Sched. 2, s. 22 (4); 2007, c. 10, Sched. M, s. 27 (1).

Idem

(5) The findings of fact in a review shall be based exclusively on the application and documentary evidence admissible or matters that may be noticed under sections 15, 15.1, 15.2 and 16 of the *Statutory Powers Procedure Act*. 1991, c. 18, Sched. 2, s. 22 (5); 2007, c. 10, Sched. M, s. 27 (2).

Disposal by Board

(6) The Board shall, after the hearing or review, make an order doing any one or more of the following:

1. Confirming the order made by the panel.
2. Requiring the Registration Committee to make an order directing the Registrar to issue a certificate of registration to the applicant if the applicant successfully completes any examinations or training the Registration Committee may specify.
3. Requiring the Registration Committee to make an order directing the Registrar to issue a certificate of registration to the applicant and to impose any terms, conditions and limitations the Board considers appropriate.
4. Referring the matter back to the Registration Committee for further consideration by a panel, together with any reasons and recommendations the Board considers appropriate. 1991, c. 18, Sched. 2, s. 22 (6); 2007, c. 10, Sched. M, s. 27 (3).

Idem

(7) The Board may make an order under paragraph 3 of subsection (6) only if the Board finds that the applicant substantially qualifies for registration and that the panel has exercised its powers improperly. 1991, c. 18, Sched. 2, s. 22 (7).

Limitation on order

(8) The Board, in making an order under subsection (6), shall not require the Registration Committee to direct the Registrar to issue a certificate of registration to an applicant who does not meet a registration requirement that is prescribed as a non-exemptible requirement. 1991, c. 18, Sched. 2, s. 22 (8).

Parties

(9) The College and the applicant are parties to a hearing or review. 1991, c. 18, Sched. 2, s. 22 (9).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 12 - 01/02/1999

2007, c. 10, Sched. M, s. 27 (1, 2) - 04/06/2007; 2007, c. 10, Sched. M, s. 27 (3) - 04/06/2009

Definitions

22.1 In this section and sections 22.2 to 22.14,

"audit" means an audit required under section 22.8; ("vérification")

"auditor" means an auditor appointed under section 22.8; ("vérificateur")

"Fairness Commissioner" means the Fairness Commissioner appointed under the *Fair Access to Regulated Professions and Compulsory Trades Act, 2006*; ("commissaire à l'équité")

"fair registration practices report" means a report required under section 22.7; ("rapport sur les pratiques d'inscription équitables")

"internationally trained individual" means an individual who has been trained in a country other than Canada to practise a health profession and who has applied for, or who intends to apply for, registration by a College; ("particulier formé à l'étranger")

"personal information" has the same meaning as in the *Freedom of Information and Protection of Privacy Act*; ("renseignements personnels")

"record" means a record as defined in the *Freedom of Information and Protection of Privacy Act*; ("document")

"regulations" means the regulations made under clauses 43 (1) (h) to (k) of the *Regulated Health Professions Act, 1991*. ("règlements") 2006, c. 31, s. 35 (3); 2017, c. 2, Sched. 9, s. 10.

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

2017, c. 2, Sched. 9, s. 10 - 22/03/2017

Fair registration practices: general duty

22.2 The College has a duty to provide registration practices that are transparent, objective, impartial and fair. 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Information

22.3 The College shall provide information on its website with respect to the requirements for registration, the procedures for applying for registration and the amount of time that the registration process usually takes. 2009, c. 24, s. 33 (4).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

2009, c. 24, s. 33 (4) - 15/12/2009

Qualifications

22.4 (1) The College shall make information publicly available on what documentation of qualifications must accompany an application and what alternatives may be acceptable to the College if an applicant cannot obtain the required documentation for reasons beyond his or her control. 2006, c. 31, s. 35 (3).

Same

(2) If the College makes its own assessment of qualifications, it shall do so in a way that is transparent, objective, impartial and fair and, if it relies on a third party to assess qualifications, it shall take reasonable measures to ensure that the third party makes the assessment in a way that is transparent, objective, impartial and fair. 2006, c. 31, s. 35 (3).

Same

(3) The College shall ensure that individuals assessing qualifications and making registration decisions or reviewing decisions have received training that includes, where appropriate,

(a) training on how to assess such qualifications and make such decisions;

(b) training in any special considerations that may apply in the assessment of applications and the process for applying those considerations. 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Functions

22.5 (1) It is the function of the Fairness Commissioner to,

(a) assess the registration practices of a College based on its obligations under this Code and the regulations;

(b) specify audit standards, the scope of audits, times when fair registration practices reports and auditors' reports shall be filed, the form of all required reports and certificates and the information that they must contain;

(c) establish eligibility requirements that a person must meet to be qualified to conduct audits;

(d) establish a roster of persons who in the opinion of the Fairness Commissioner have satisfied the eligibility requirements established under clause (c);

(e) consult with Colleges on the cost, scope and timing of audits;

(f) monitor third parties relied on by a College to assess the qualifications of individuals applying for registration by the College to help ensure that assessments are based on the obligations of the College under this Code and the regulations;

(g) advise a College or third parties relied on by a College to assess qualifications with respect to matters related to registration practices under this Code and the regulations;

(h) provide advice and recommendations to the Minister, including advice and recommendations that a College do or refrain from doing any action respecting a contravention by a College if the Fairness Commissioner determines that the College has failed to comply with any requirement imposed on it by sections 22.2 to 22.11; and

(i) perform such other functions as may be assigned by the Lieutenant Governor in Council. 2006, c. 31, s. 35 (3).

Scope

(2) A matter specified under clause (1) (b) or established under clause (1) (c) or (d) may be general or specific in its application and may be limited as to time and place. 2006, c. 31, s. 35 (3).

Same

(3) The Fairness Commissioner shall give notice to the College of all matters specified under clause (1) (b) and established under clauses (1) (c) and (d) and the notice may be given in the manner he or she considers appropriate. 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Review of practices

22.6 (1) The College shall undertake reviews of its registration practices at such times as the Fairness Commissioner may specify to ensure that the registration practices are transparent, objective, impartial and fair. 2006, c. 31, s. 35 (3).

Same

(2) The review shall include an analysis of,

(a) the extent to which the requirements for registration are necessary for or relevant to the practice of the profession;

(b) the efficiency and timeliness of decision-making; and

(c) the reasonableness of the fees charged by the College in respect of applications. 2006, c. 31, s. 35 (3).

Reports

(3) The College shall file a copy of the results of the review with the Fairness Commissioner within 30 days after the completion of the review. 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Fair registration practices reports

22.7 (1) The College shall prepare a fair registration practices report annually or at such other times as the Fairness Commissioner may specify. 2006, c. 31, s. 35 (3).

Same

(2) The College may combine its fair registration practices report with such other report of the College as the Fairness Commissioner may permit and in such case an audit shall be confined to those parts of the report that relate to registration practices. 2006, c. 31, s. 35 (3).

Other reports

(3) The Fairness Commissioner may require that the College provide the Fairness Commissioner with reports or information relating to the College's compliance with sections 15 to 22.11 and the regulations and the College shall prepare and file the reports with, or provide the information to, the Fairness Commissioner. 2006, c. 31, s. 35 (3).

Same

(4) Reports and information required under subsection (3) are in addition to the reports required under subsection (1) and section 22.8. 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Audits

22.8 (1) Every three years or at such other times as the Fairness Commissioner may specify, the Fairness Commissioner shall give notice to the College that an audit must be conducted in respect of its registration practices and of its compliance with this Code and the regulations. 2006, c. 31, s. 35 (3).

Notice of audit

(2) The Fairness Commissioner shall give the notice required by subsection (1) at least 90 days before the audit is to begin and the notice shall state,

(a) that the College must choose and appoint an auditor from the roster established by the Fairness Commissioner by the date specified in the notice;

(b) that if the College fails to choose and appoint an auditor by the date specified in the notice that the Fairness Commissioner will choose the auditor;

(c) the scope of the audit and the standards that will apply;

(d) the date by which the audit must be completed; and

(e) that the College is responsible for the payment of the auditor's fees and expenses. 2006, c. 31, s. 35 (3).

Choice of auditor

(3) The College shall, by the date specified in the notice, choose and appoint an auditor from the roster established by the Fairness Commissioner and notify the Fairness Commissioner of its choice. 2006, c. 31, s. 35 (3).

Failure to choose

(4) If the College fails to notify the Fairness Commissioner of the name of the auditor it has chosen and appointed by the date specified in the notice, the Fairness Commissioner shall choose the auditor and notify the College of his or her choice and the auditor shall be deemed to have been appointed by the College. 2006, c. 31, s. 35 (3).

Auditor's duties

(5) The auditor chosen and appointed under subsection (3) or (4) shall begin the audit promptly, shall conduct it in accordance with the scope of the audit and the audit standards set out in the notice under subsection (2) and shall complete it by the date set out in the notice. 2006, c. 31, s. 35 (3).

Collection of personal information

(6) An auditor may collect personal information, directly or indirectly, only for the purpose of an audit required under this section, but an auditor shall not retain any personal information after completing the audit and shall not include any personal information in any draft report or final report submitted in accordance with this section. 2006, c. 31, s. 35 (3).

Duty to furnish information

(7) A College shall co-operate with the auditor and shall,

(a) produce such records for, and provide such other information to, the auditor regarding its registration practices and any other matters related to compliance by the College with its obligations under sections 15 to 22.11 and the regulations as are reasonably necessary for the auditor to perform his or her duties under this Code, including any reports required from the College under section 22.6, 22.7 or 22.9 or the regulations; and

(b) provide the auditor with any assistance that is reasonably necessary, including assistance in using any data storage, processing or retrieval device or system, to produce a record in readable form. 2006, c. 31, s. 35 (3).

Limitation

(8) Despite subsection (7), a College may refuse access to a record if,

(a) the record or any information in the record is subject to a legal privilege that restricts disclosure of the record or the information; or

(b) an Act of Ontario or of Canada or a court order prohibits disclosure of the record or any information in the record in the circumstances. 2006, c. 31, s. 35 (3).

Draft report

(9) The auditor shall prepare a draft report on the audit and provide a copy of it to the College, together with a notice that the College may, within 30 days, make submissions to the auditor on the draft report. 2006, c. 31, s. 35 (3).

Same

(10) The auditor shall consider the submissions, if any, made by the College and may make any changes the auditor considers appropriate before finalizing the report. 2006, c. 31, s. 35 (3).

Auditor's reports

(11) The auditor shall make a final report on the audit and shall file it with the Fairness Commissioner and provide a copy to the College to which the audit relates. 2006, c. 31, s. 35 (3).

Auditor's certificate

(12) The auditor shall file a certificate with the Fairness Commissioner certifying that the auditor made the audit in accordance with this Act and the regulations and that he or she has provided a copy of the auditor's report to the College. 2006, c. 31, s. 35 (3).

When audit is complete

(13) An audit is complete when the auditor has provided a copy of the final report to the College to which the audit relates and has filed with the Fairness Commissioner the final report and the certificate referred to in subsection (12) and, if the College made submissions to the auditor on the draft report, a copy of the submissions made by the College. 2006, c. 31, s. 35 (3).

Filing with Minister

(14) The Fairness Commissioner shall provide the Minister of Health and Long-Term Care with a copy of all auditors' reports within a reasonable time after receiving them. 2006, c. 31, s. 35 (3).

Auditor's fees and expenses

(15) The College shall pay the auditor's fees and expenses. 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Filing of reports by College

22.9 (1) The College shall file its fair registration practices reports with the Fairness Commissioner by the dates specified by the Fairness Commissioner. 2006, c. 31, s. 35 (3).

Report available to public

(2) The College shall make reports filed under subsection (1) available to the public. 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Form of reports

22.10 (1) Reports and certificates required by sections 22.7 and 22.8 and under the regulations shall be in the form and contain the information specified by the Fairness Commissioner or as may be specified in the regulations. 2006, c. 31, s. 35 (3).

Restriction on personal information

(2) Despite subsection (1), no report prepared by the College, the Fairness Commissioner or an auditor under sections 22.6 to 22.8 shall contain personal information. 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Certification of report

22.11 (1) A fair practices registration report shall include a statement certifying that all the information required to be provided in the report has been provided and that the information is accurate. 2006, c. 31, s. 35 (3).

Signature

(2) A person with authority to sign on behalf of the College shall sign the statement required by subsection (1). 2006, c. 31, s. 35 (3).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

Offences

22.12 (1) A person is guilty of an offence who,

(a) furnishes false or misleading information in a fair registration practices report or other report or record filed with the Fairness Commissioner under this Code or otherwise provides false or misleading information to the Fairness Commissioner or to a person employed in the Office of the Fairness Commissioner;

(b) obstructs the Fairness Commissioner or a person employed in the Office of the Fairness Commissioner in exercising powers or performing duties under this Code;

(c) furnishes false or misleading information to an auditor;

(d) obstructs, fails to co-operate with or assist an auditor; or

(e) contravenes subsection (2). 2006, c. 31, s. 35 (3); 2017, c. 2, Sched. 9, s. 11 (1).

Same, intimidation

(2) No person shall intimidate, coerce, penalize or discriminate against another person because that person,

(a) has co-operated or may co-operate with the Fairness Commissioner, an auditor or a person employed in the Office of the Fairness Commissioner in exercising powers or performing duties under this Code; or

(b) has provided, or may provide, records or other information in the course of an audit or other activity or proceeding under this Code in respect of fair registration practices. 2006, c. 31, s. 35 (3); 2017, c. 2, Sched. 9, s. 11 (2).

Penalties

(3) Every person who is guilty of an offence under subsection (1) is liable on conviction,

(a) to a fine of not more than $50,000; or

(b) if the person is a corporation, to a fine of not more than $100,000. 2006, c. 31, s. 35 (3); 2009, c. 33, Sched. 18, s. 29 (1).

Consent to prosecution

(4) No prosecution for an offence under subsection (1) shall be instituted except with the consent in writing of the Attorney General. 2006, c. 31, s. 35 (3); 2009, c. 33, Sched. 18, s. 29 (2).

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

2009, c. 33, Sched. 18, s. 29 (1, 2) - 15/12/2009

2017, c. 2, Sched. 9, s. 11 (1, 2) - 01/09/2017

Immunity

22.13 (1) No proceeding shall be commenced against the Fairness Commissioner or anyone employed in the Office of the Fairness Commissioner for any act done or omitted in good faith in the execution or intended execution of his or her duties under this Code. 2006, c. 31, s. 35 (3); 2017, c. 2, Sched. 9, s. 12.

Testimony

(2) Neither the Fairness Commissioner nor anyone employed in the Office of the Fairness Commissioner is a competent or compellable witness in a civil proceeding outside this Code in connection with anything done under this Code. 2006, c. 31, s. 35 (3); 2017, c. 2, Sched. 9, s. 12.

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

2017, c. 2, Sched. 9, s. 12 - 01/09/2017

Limitation on powers

22.14 Neither the Fairness Commissioner nor anyone employed in the Office of the Fairness Commissioner,

(a) has power to influence a registration decision by the College or Registration Committee, to provide representation or advice to an applicant or potential applicant for registration in respect of a registration decision or to otherwise involve himself or herself in a registration decision or any review decision on behalf of an applicant or potential applicant for registration;

(b) has status at any proceeding of a College, the Registration Committee, the Board, a court or other tribunal in relation to any matter arising from an application for registration; or

(c) has the power to act as legal counsel or agent for any person in a proceeding described in clause (b) or in preparing for the proceeding. 2006, c. 31, s. 35 (3); 2017, c. 2, Sched. 9, s. 12.

Section Amendments with date in force (d/m/y)

2006, c. 31, s. 35 (3) - 01/03/2007

2017, c. 2, Sched. 9, s. 12 - 01/09/2017

Definitions

22.15 (1) In this section and in sections 22.16 to 22.23,

"Agreement on Internal Trade" means the Agreement on Internal Trade signed in 1994 by the governments of Canada, the provinces of Canada, the Northwest Territories and the Yukon Territory, as amended from time to time; ("Accord sur le commerce intérieur")

"occupational standards", in relation to a certificate of registration, means the knowledge, skills and judgment that an individual must possess in order to be issued the certificate of registration, as established by the College, and against which the College measures the qualifications of an applicant for registration when assessing whether the applicant is

qualified to practise the profession to the extent permitted by the certificate of registration; ("normes professionnelles")

"out-of-province certificate" means a certificate, licence, registration, or other form of official recognition that,

(a) attests to an individual being qualified to practise the profession and authorizes the individual to practise the profession, use a title or designation relating to the profession, or both, and

(b) is granted to the individual by a body or individual that is authorized under an Act of Canada or of a province or territory of Canada that is a party to the Agreement on Internal Trade, other than Ontario, to grant such certificate, licence, registration, or other form of official recognition. ("certificat extraprovincial") 2009, c. 24, s. 33 (5).

Federal Act

(2) For greater certainty, the reference in clause (b) of the definition of "out-of-province certificate" in subsection (1), to an Act of Canada that authorizes a body or individual to grant a certificate, licence, registration, or other form of official recognition, does not include the *Trade-marks Act* (Canada). 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

Purposes

22.16 The purposes of sections 22.15 to 22.23 are,

(a) to eliminate or reduce measures established or implemented by the College that restrict or impair the ability of an individual to obtain a certificate of registration when the individual holds an equivalent out-of-province certificate; and

(b) to support the Government of Ontario in fulfilling its obligations under Chapter Seven of the Agreement on Internal Trade. 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

Ontario residency cannot be required

22.17 The College shall not make it a registration requirement that an applicant reside in Ontario, if the applicant resides in another province or territory of Canada that is a party to the Agreement on Internal Trade. 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

When applicant holds out-of-province certificate

22.18 (1) This section applies if an individual applying to the College for registration already holds an out-of-province certificate that is equivalent to the certificate of registration being applied for. 2009, c. 24, s. 33 (5).

Material additional training, etc., cannot be required

(2) The College shall not impose any registration requirement that would require the applicant to have, undertake, obtain or undergo any material additional training, experience, examinations or assessments. 2009, c. 24, s. 33 (5).

Exception, registration requirements listed on website

(3) Despite subsection (2), the College is not prohibited from imposing on the applicant any registration requirement that,

(a) is listed on the publicly accessible website referred to in clause 9 (3) (a) of the *Ontario Labour Mobility Act, 2009*; and

(b) is stated on the website to be a permissible registration requirement for the certificate of registration being applied for, adopted by the Government of Ontario under Article 708 of the Agreement on Internal Trade. 2009, c. 24, s. 33 (5).

Other exceptions

(4) Despite subsection (2), if the conditions set out in subsection (6) are met, the College is not prohibited from imposing one or both of the following registration requirements on the applicant:

1. Requiring the applicant to demonstrate proficiency in English or in French if equivalent proficiency in the language was not a requirement for the granting of the out-of-province certificate.
2. Requiring the applicant to undertake, obtain or undergo material additional training, experience, examinations or assessments if the applicant has not, within a period of time fixed by the College, before submitting the application for registration, practised the profession to the extent that would be permitted by the certificate of registration for which the applicant is applying. 2009, c. 24, s. 33 (5).

Other permitted registration requirements

(5) Subsection (2) does not prohibit the College from imposing registration requirements that would require the applicant to do one or more of the following:

1. If the conditions set out in subsection (6) are met:
   i. Pay a fee upon application for registration and upon registration.
   ii. Obtain professional liability insurance or any other insurance or similar protection.
   iii. Post a bond.
   iv. Undergo a criminal background check.

Note: On November 1, 2018, the day named by proclamation of the Lieutenant Governor, subparagraph 1 iv of subsection 22.18 (5) of Schedule 2 to the Act is amended by striking out "criminal background check" and substituting "police record check". (See: 2015, c. 30, s. 28)

   v. Provide evidence of good character.
2. If the condition set out in paragraph 2 of subsection (6) is met, provide a certificate, letter or other evidence from every body or individual from whom the applicant currently holds an out-of-province certificate, confirming that the out-of-province certificate is in good standing.
3. If the conditions set out in subsection (6) are met, demonstrate knowledge of matters applicable to the practice of the profession in Ontario, as long as this does not involve material additional training, experience, examinations or assessments.
4. If the conditions set out in subsection (6) are met, meet any other requirement specified by the College that does not involve material additional training, experience, examinations or assessments. 2009, c. 24, s. 33 (5).

Conditions for subss. (4) and (5)

(6) The conditions referred to in subsections (4) and (5) are:

1. Subject to subsection (9), the requirement imposed by the College on applicants who hold an out-of-province certificate must be the same as, or substantially similar to but no more onerous than, the requirement imposed by the College on applicants who do not hold an out-of-province certificate.
2. The requirement imposed by the College must not be a disguised restriction on labour mobility. 2009, c. 24, s. 33 (5).

Permitted measures

(7) This section does not prohibit the College from carrying out the following measures in respect of the applicant if the conditions set out in subsection (8) are met:

1. Refusing to issue a certificate of registration to the applicant or imposing terms, conditions or limitations on the applicant's certificate of registration if, in the opinion of the

Registration Committee, such action is necessary to protect the public interest as a result of complaints, or criminal, disciplinary or other proceedings, against the applicant in any jurisdiction whether in or outside Canada, relating to the applicant's competency, conduct or character.

2. If the out-of-province certificate held by the applicant is subject to a term, condition or limitation,
   i. imposing an equivalent term, condition or limitation on the certificate of registration to be issued to the applicant, or
   ii. refusing to register the applicant, if the College does not impose an equivalent term, condition or limitation on the certificate of registration being applied for. 2009, c. 24, s. 33 (5).

Conditions for subs. (7)

(8) The conditions referred to in subsection (7) are:

1. Subject to subsection (9), the measure carried out by the College with respect to applicants who hold an out-of-province certificate must be the same as, or substantially similar to but no more onerous than, the measure carried out by the College with respect to applicants who do not hold an out-of-province certificate.
2. The measure carried out by the College must not be a disguised restriction on labour mobility. 2009, c. 24, s. 33 (5).

Costs

(9) The College shall ensure that any registration requirements it imposes on the applicant and any measures it carries out with respect to the applicant in connection with the registration of the applicant do not result in the imposition on the applicant of fees or other costs that are more onerous than those the College would impose if the applicant did not hold an out-of-province certificate, unless the difference in such fees or other costs reflects the actual cost differential to the College. 2009, c. 24, s. 33 (5).

Expeditious registration

(10) The College shall ensure that its imposition of registration requirements on the applicant under subsections (3), (4) and (5) and its imposition of terms, conditions or limitations on the applicant's certificate of registration under subsection (7) do not prevent the expeditious registration of the applicant. 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

2015, c. 30, s. 28 - 01/11/2018

Transition

22.19 Sections 22.17 and 22.18 apply to,

(a) an application for registration made to the College on or after the day this section comes into force; and

(b) an application for registration made to the College before the day this section comes into force, if the application has not been finally decided before that day. 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

Occupational standards

22.20 (1) The College shall, to the extent possible and where practical,

(a) ensure that the process it follows in establishing or amending occupational standards for certificates of registration is conducive to labour mobility within Canada;

(b) take steps to reconcile differences between the occupational standards it has established for certificates of registration and occupational standards in effect with respect to the

profession in the other provinces and territories of Canada that are parties to the Agreement on Internal Trade; and

(c) ensure that the occupational standards it establishes for certificates of registration are consistent with such common interprovincial or international occupational standards as may have been developed for the profession. 2009, c. 24, s. 33 (5).

No limitation

(2) Subsection (1) does not limit the objects of the College under section 3 or the powers of the Council under section 95 to establish such occupational standards for the profession as it considers appropriate to protect the public. 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

Notice of proposed occupational standards

22.21 If the College wishes to establish or amend occupational standards for a certificate of registration, it shall,

(a) give notice of the proposed new or amended standards to,

(i) the Minister,

(ii) the co-ordinating Minister under the *Ontario Labour Mobility Act, 2009*, and

(iii) the granting bodies and individuals referred to in clause (b) of the definition of "out-of-province certificate" in subsection 22.15 (1); and

(b) afford those granting bodies and individuals an opportunity to comment on the development of the new or amended standards. 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

Conflict

22.22 (1) If any of sections 22.16 to 22.21 conflicts with the health profession Act or a regulation or by-law made under the health profession Act or under this Code, sections 22.16 to 22.21 prevail to the extent of the conflict. 2009, c. 24, s. 33 (5).

Same

(2) This conflict provision prevails over any other conflict provision in the health profession Act, even if the other conflict provision is enacted after this one, unless the other conflict provision refers expressly to sections 22.16 to 22.21 of this Code. 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

Regulations and by-laws to conform

22.23 Within 12 months after the day this section comes into force or within such longer period as may be prescribed, the Council shall take such steps as are within its power to make, amend or revoke regulations and by-laws under this Code and under the health profession Act so that they conform with sections 22.16 to 22.21 of this Code. 2009, c. 24, s. 33 (5).

Section Amendments with date in force (d/m/y)

2009, c. 24, s. 33 (5) - 15/12/2009

Register

23 (1) The Registrar shall maintain a register. 2007, c. 10, Sched. M, s. 28.

Contents of register

(2) The register shall contain the following:

1. Each member's name, business address and business telephone number, and, if applicable, the name of every health profession corporation of which the member is a shareholder.
2. Where a member is deceased, the name of the deceased member and the date upon which the member died, if known to the Registrar.
3. The name, business address and business telephone number of every health profession corporation.
4. The names of the shareholders of each health profession corporation who are members of the College.
5. Each member's class of registration and specialist status.
6. The terms, conditions and limitations that are in effect on each certificate of registration.
7. A notation of every caution that a member has received from a panel of the Inquiries, Complaints and Reports Committee under paragraph 3 of subsection 26 (1), and any specified continuing education or remedial programs required by a panel of the Inquiries, Complaints and Reports Committee using its powers under paragraph 4 of subsection 26 (1).
8. A notation of every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee under section 26 and that has not been finally resolved, including the date of the referral and the status of the hearing before a panel of the Discipline Committee, until the matter has been resolved.
9. A copy of the specified allegations against a member for every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee under section 26 and that has not been finally resolved.
10. Every result of a disciplinary or incapacity proceeding.
11. A notation and synopsis of any acknowledgements and undertakings in relation to matters involving allegations of professional misconduct or incompetence before the Inquiries, Complaints and Reports Committee or the Discipline Committee that a member has entered into with the College and that are in effect.
12. A notation of every finding of professional negligence or malpractice, which may or may not relate to the member's suitability to practise, made against the member, unless the finding is reversed on appeal.
13. A notation of every revocation or suspension of a certificate of registration.
14. A notation of every revocation or suspension of a certificate of authorization.
15. Information that a panel of the Registration Committee, Discipline Committee or Fitness to Practise Committee specifies shall be included.
16. Where findings of the Discipline Committee are appealed, a notation that they are under appeal, until the appeal is finally disposed of.
17. Where, during or as a result of a proceeding under section 25, a member has resigned and agreed never to practise again in Ontario, a notation of the resignation and agreement.
18. Where the College has an inspection program established under clause 95 (1) (h) or (h.1), the outcomes of inspections conducted by the college.
19. Information that is required to be kept in the register in accordance with regulations made pursuant to clause 43 (1) (t) of the *Regulated Health Professions Act, 1991*.
20. Information that is required to be kept in the register in accordance with the by-laws. 2017, c. 11, Sched. 5, s. 11 (1).

Publication ban

(3) No action shall be taken under this section which violates a publication ban, and nothing in this section requires or authorizes the violation of a publication ban. 2007, c. 10, Sched. M, s. 28.

Panels specifying information in register

(4) In disposing of a matter, a panel of the Registration, Discipline or Fitness to Practise Committee may, for the purposes of paragraph 15 of subsection (2), specify information that is to be included in the register in addition to the information specified in other paragraphs of subsection (2). 2007, c. 10, Sched. M, s. 28; 2017, c. 11, Sched. 5, s. 11 (2).

Access to information by the public

(5) All of the information required by paragraphs 1 to 19 of subsection (2) and all information designated as public in the by-laws shall, subject to subsections (6), (7), (8), (9) and (11), be made available to an individual during normal business hours, and shall be posted on the College's website within a reasonable amount of time of the Registrar having received the information and in a manner that is accessible to the public or in any other manner and form specified by the Minister. 2017, c. 11, Sched. 5, s. 11 (3).

When information may be withheld from the public

(6) The Registrar may refuse to disclose to an individual or to post on the College's website an address or telephone number or other information designated as information to be withheld from the public in the by-laws if the Registrar has reasonable grounds to believe that disclosure may jeopardize the safety of an individual. 2007, c. 10, Sched. M, s. 28.

Same

(7) The Registrar may refuse to disclose to an individual or to post on the College's website information that is available to the public under subsection (5), if the Registrar has reasonable grounds to believe that the information is obsolete and no longer relevant to the member's suitability to practise. 2007, c. 10, Sched. M, s. 28.

Same, personal health information

(8) The Registrar shall not disclose to an individual or post on the College's website information that is available to the public under subsection (5) that is personal health information, unless the personal health information is that of a member and it is in the public interest that the information be disclosed. 2007, c. 10, Sched. M, s. 28.

Restriction, personal health information

(9) The Registrar shall not disclose to an individual or post on the College's website under subsection (8) more personal health information than is reasonably necessary. 2007, c. 10, Sched. M, s. 28.

Personal health information

(10) In subsections (8) and (9),

"personal health information" means information that identifies an individual and that is referred to in clauses (a) through (g) of the definition of "personal health information" in subsection 4 (1) of the *Personal Health Information Protection Act, 2004*. 2007, c. 10, Sched. M, s. 28.

Other cases when information may be withheld

(11) The Registrar shall refuse to disclose to an individual or to post on the College's website information required by paragraph 10 of subsection (2) if,

(a) a finding of professional misconduct was made against the member and the order made was only a reprimand or only a fine, or a finding of incapacity was made against the member;

(b) more than six years have passed since the information was prepared or last updated;

(c) the member has made an application to the relevant committee for the removal of the information from public access because the information is no longer relevant to the member's suitability to practise, and if,

(i) the relevant committee believes that a refusal to disclose the information outweighs the desirability of public access to the information in the interest of any person affected or the public interest, and

(ii) the relevant committee has directed the Registrar to remove the information from public access; and

(d) the information does not relate to disciplinary proceedings concerning sexual abuse as defined in clause (a), (b) or (c) of the definition of "sexual abuse" in subsection 1 (3). 2007, c. 10, Sched. M, s. 28; 2017, c. 11, Sched. 5, s. 11 (4, 5).

Other cases when information may be withheld

(11.1) The Registrar shall refuse to disclose to an individual or to post on the College's website information required by paragraph 10 of subsection (2) if,

(a) the result of a discipline proceeding was that no finding of professional misconduct or incompetence was made against the member; and

(b) more than 90 days have passed since the information was prepared or last updated, unless before the expiry of the 90 days the member to whom the information relates specifically requests in writing that the Registrar continue to maintain public access to the information. 2017, c. 11, Sched. 5, s. 11 (6).

Information from register

(12) The Registrar shall provide to an individual a copy of any information in the register that the individual is entitled to obtain, upon the payment of a reasonable fee, if required. 2007, c. 10, Sched. M, s. 28.

Positive obligation

(13) Subject to subsection (11), where an individual inquires about a member, the Registrar shall make reasonable efforts to ensure that the individual is provided with a list of the information that is available to the public under subsection (5). 2007, c. 10, Sched. M, s. 28.

Correction of information

(13.1) The Registrar shall correct any information contained in the register that is required by paragraph 12 of subsection (2) or that is both required by paragraph 19 of subsection (2) and designated as subject to this subsection in a regulation made under clause 43 (1) (t) of the *Regulated Health Professions Act, 1991*, where a member demonstrates, to the satisfaction of the Registrar, that the information contained in the register is incomplete or inaccurate and where the member provides the Registrar with the information that is necessary to enable the Registrar to correct the incomplete or inaccurate information. 2017, c. 11, Sched. 5, s. 11 (7).

Meaning of results of proceeding

(14) For the purpose of this section and section 56,

"result",

(a) when used in reference to a disciplinary proceeding, means the panel's finding that the member committed an act of professional misconduct or was incompetent, particulars of the grounds for the finding, a synopsis of the decision and the order made, including any reprimand, and where the panel has made no such finding, includes a notation that no such finding was made and the reason why no such finding was made, and

(b) when used in reference to an incapacity proceeding, means the panel's finding that the member is incapacitated and the order made by the panel. 2017, c. 11, Sched. 5, s. 11 (8).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 7 (1-5) - 31/12/1993; 1998, c. 18, Sched. G, s. 13 (1-3) - 01/02/1999

2000, c. 42, Sched., s. 35 (1, 2) - 01/11/2001

2001, c. 8, s. 218 (1-3) - 01/11/2001

2007, c. 10, Sched. M, s. 28 - 04/06/2009

2017, c. 11, Sched. 5, s. 11 (1-8) - 30/05/2017

Suspension for non-payment of fees

24 If a member fails to pay a fee that he or she is required to pay in accordance with the by-laws, the Registrar shall give the member notice of intention to suspend the member and may suspend the member's certificate of registration for failure to pay the fee 30 days after notice is given. 1998, c. 18, Sched. G, s. 14; 2007, c. 10, Sched. M, s. 29.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 14 - 01/02/1999

2007, c. 10, Sched. M, s. 29 - 04/06/2009

COMPLAINTS AND REPORTS

Panel for investigation or consideration

25 (1) A panel shall be selected by the chair of the Inquiries, Complaints and Reports Committee from among the members of the Committee to investigate a complaint filed with the Registrar regarding the conduct or actions of a member or to consider a report that is made by the Registrar under clause 79 (a). 2007, c. 10, Sched. M, s. 30.

Composition

(2) A panel shall be composed of at least three persons, at least one of whom shall be a person appointed to the Council by the Lieutenant Governor in Council. 2007, c. 10, Sched. M, s. 30.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 25 (2) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 12)

Composition of panels

(2) The panel selected by the chair shall be composed in accordance with regulations made pursuant to clauses 43 (1) (p) to (s) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 12.

Quorum

(3) Three members of a panel constitute a quorum. 2007, c. 10, Sched. M, s. 30.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 25 (3) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 12)

Quorum

(3) Quorum for the panel shall be in accordance with regulations made pursuant to clause 43 (1) (s) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 12.

Complaint must be recorded

(4) A panel shall not be selected to investigate a complaint unless the complaint is in writing or is recorded on a tape, film, disk or other medium. 2007, c. 10, Sched. M, s. 30.

Complainant to be informed

(5) The Registrar shall give a complainant notice of receipt of his or her complaint and a general explanation of the processes of the College, including the jurisdiction and role of the Inquiries, Complaints and Reports Committee, together with a copy of the provisions of sections 28 to 29. 2007, c. 10, Sched. M, s. 30.

Notice to member

(6) The Registrar shall give the member, within 14 days of receipt of the complaint or the report,

(a) notice of the complaint, together with a copy of the provisions of sections 28 to 29, or notice of the receipt of the report;

(b) a copy of the provisions of section 25.2; and

(c) a copy of all available prior decisions involving the member unless the decision was to take no further action under subsection 26 (5). 2007, c. 10, Sched. M, s. 30.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 30 - 04/06/2009

2017, c. 11, Sched. 5, s. 12 - not in force

Alternative dispute resolution with respect to a complaint

25.1 (1) The Registrar may, with the consent of both the complainant and the member, refer the complainant and the member to an alternative dispute resolution process,

(a) if the matter has not yet been referred to the Discipline Committee under section 26; and

(b) if the matter does not involve an allegation of sexual abuse. 2007, c. 10, Sched. M, s. 30.

Confidentiality

(2) Despite this or any other Act, all communications at an alternative dispute resolution process and the facilitator's notes and records shall remain confidential and be deemed to have been made without prejudice to the parties in any proceeding. 2007, c. 10, Sched. M, s. 30.

Facilitator not to participate

(3) The person who acts as the alternative dispute resolution facilitator shall not participate in any proceeding concerning the same matter. 2007, c. 10, Sched. M, s. 30.

Ratification of resolution

(4) If the complainant and the member reach a resolution of the complaint through alternative dispute resolution, they shall advise the Registrar of the resolution, and the Registrar may,

(a) adopt the proposed resolution; or

(b) refer the decision of whether or not to adopt the proposed resolution to the panel. 2017, c. 11, Sched. 5, s. 13.

Referral to panel

(5) Where the Registrar makes a referral to the panel under clause (4) (b), the panel may,

(a) adopt the proposed resolution; or

(b) continue with its investigation of the complaint. 2017, c. 11, Sched. 5, s. 13.

Time limit for ADR

(6) If the complainant and the member do not reach a resolution of the complaint within 60 days of a referral to alternative dispute resolution under subsection (1), the Registrar or the panel shall not adopt any resolution reached after that date and the panel shall proceed with its investigation of the complaint. 2017, c. 11, Sched. 5, s. 13.

Extension of time

(7) Despite subsection (6), the Registrar or the panel may, where the Registrar or the panel believes it is in the public interest to do so, and with the agreement of the complainant and the member, adopt a resolution reached within 120 days of a referral to alternative dispute resolution under subsection (1). 2017, c. 11, Sched. 5, s. 13.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 30 - 04/06/2009

2017, c. 11, Sched. 5, s. 13 - 30/05/2017

Submissions by member

25.2 (1) A member who is the subject of a complaint or a report may make written submissions to the Inquiries, Complaints and Reports Committee within 30 days of receiving notice under subsection 25 (6). 2007, c. 10, Sched. M, s. 30.

Exception

(2) The Inquiries, Complaints and Reports Committee may specify a period of time of less than 30 days in which the member may make written submissions, and inform the member to that effect, if the Committee is of the opinion, on reasonable and probable grounds, that the conduct of the member exposes or is likely to expose his or her patients to harm or injury. 2007, c. 10, Sched. M, s. 30.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 30 - 04/06/2009

Withdrawal of complaint by Registrar

25.3 (1) At any time following the receipt of a complaint regarding the conduct or actions of a member and prior to any action being taken by a panel of the Inquiries, Complaints and Reports Committee under subsection 26 (1), the Registrar may, at the request of the complainant, withdraw the complaint if the Registrar believes that the withdrawal is in the public interest. 2017, c. 11, Sched. 5, s. 14.

Notice

(2) The Registrar shall give the complainant and the member, within 14 days of the Registrar having withdrawn the complaint, notice that the complaint has been withdrawn. 2017, c. 11, Sched. 5, s. 14.

Section Amendments with date in force (d/m/y)

2017, c. 11, Sched. 5, s. 14 - 30/05/2017

Interim suspension

25.4 (1) The Inquiries, Complaints and Reports Committee may, subject to subsections (2) and (6), at any time following the receipt of a complaint or following the appointment of an investigator pursuant to subsection 75 (1) or (2), make an interim order directing the Registrar to suspend, or to impose terms, conditions or limitations on, a member's certificate of registration if it is of the opinion that the conduct of the member exposes or is likely to expose the member's patients to harm or injury. 2017, c. 11, Sched. 5, s. 14.

No gender-based terms, conditions, limitations

(2) Despite subsection (1), the Inquiries, Complaints and Reports Committee shall not make an interim order directing the Registrar to impose any gender-based terms, conditions or limitations on a member's certificate of registration. 2017, c. 11, Sched. 5, s. 14.

Procedure following interim suspension

(3) If an order is made under subsection (1) by the Inquiries, Complaints and Reports Committee,

(a) the matter shall be investigated and prosecuted expeditiously; and

(b) the Inquiries, Complaints and Reports Committee, the Discipline Committee or the Fitness to Practise Committee, as the case may be, shall give precedence to the matter. 2017, c. 11, Sched. 5, s. 14.

Duration of order

(4) An order under subsection (1) continues in force until it is varied by the Inquiries, Complaints and Reports Committee or until the matter is withdrawn, resolved by way of an alternative dispute resolution process or otherwise finally disposed of by a panel of the

Inquiries, Complaints and Reports Committee, the Discipline Committee or the Fitness to Practise Committee. 2017, c. 11, Sched. 5, s. 14.

Panel's order

(5) In a matter in which an order under subsection (1) was made, an order of a panel of the Discipline Committee or the Fitness to Practise Committee directing the Registrar to revoke, suspend or impose conditions on a member's certificate takes effect immediately despite any appeal. 2017, c. 11, Sched. 5, s. 14.

Restrictions on orders

(6) No order shall be made under subsection (1) unless the member has been given,

(a) notice of the intention to make the order;

(b) at least 14 days to make written submissions to the Committee; and

(c) a copy of the provisions of this section. 2017, c. 11, Sched. 5, s. 14.

Extraordinary action to protect public

(7) Despite subsection (6), an order may be made under subsection (1) without notice to the member, subject to the right of the member to make submissions while the suspension or the terms, conditions or limitations are in place, if the Committee is of the opinion, on reasonable and probable grounds, that the conduct of the member exposes or is likely to expose the member's patients to harm or injury and urgent intervention is needed. 2017, c. 11, Sched. 5, s. 14.

Section Amendments with date in force (d/m/y)

2017, c. 11, Sched. 5, s. 14 - 30/05/2017

What a panel may do

26 (1) A panel, after investigating a complaint or considering a report, considering the submissions of the member and making reasonable efforts to consider all records and documents it considers relevant to the complaint or the report, may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or the report.
2. Refer the member to a panel of the Inquiries, Complaints and Reports Committee under section 58 for incapacity proceedings.
3. Require the member to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned.
4. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws. 2007, c. 10, Sched. M, s. 30.

Prior decisions

(2) A panel of the Inquiries, Complaints and Reports Committee shall, when investigating a complaint or considering a report currently before it, consider all of its available prior decisions involving the member, including decisions made when that committee was known as the Complaints Committee, and all available prior decisions involving the member of the Discipline Committee, the Fitness to Practise Committee and the Executive Committee, unless the decision was to take no further action under subsection (5). 2007, c. 10, Sched. M, s. 30.

Quality assurance

(3) In exercising its powers under paragraph 4 of subsection (1), the panel may not refer the matter to the Quality Assurance Committee, but may require a member to complete a specified continuing education or remediation program. 2007, c. 10, Sched. M, s. 30.

Complaint in bad faith, etc.

(4) If the panel considers a complaint to be frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process, it shall give the complainant and the member notice that it

intends to take no action with respect to the complaint and that the complainant and the member have a right to make written submissions within 30 days after receiving the notice. 2007, c. 10, Sched. M, s. 30.

Same

(5) If the panel is satisfied, after considering the written submissions of the complainant and the member, that a complaint was frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process, the panel shall not take action with respect to the complaint. 2007, c. 10, Sched. M, s. 30.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 15 - 01/02/1999

2007, c. 10, Sched. M, s. 30 - 04/06/2009

Notice of decision

27 (1) A panel shall give the complainant and the member who is the subject of the complaint,

(a) a copy of its decision;

(b) a copy of its reasons, if the panel acted under paragraph 3 or 4 of subsection 26 (1); and

(c) a notice advising the member and the complainant of any right to request a review they may have under subsection 29 (2). 2007, c. 10, Sched. M, s. 30.

Same, report

(2) A panel shall give the member, in the case of a report,

(a) a copy of its decision; and

(b) a copy of its reasons, if the panel acted under paragraph 3 or 4 of subsection 26 (1). 2007, c. 10, Sched. M, s. 30.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 30 - 04/06/2009

Timely disposal

28 (1) A panel shall dispose of a complaint within 150 days after the filing of the complaint. 2007, c. 10, Sched. M, s. 30.

Impact of ADR on timelines

(2) Time spent by a complainant and member in an alternative dispute resolution process pursuant to a referral under section 25.1 shall not be included in the calculation of time under this section. 2017, c. 11, Sched. 5, s. 15.

If complaint not disposed of

(3) If a panel has not disposed of a complaint within 150 days after the complaint was filed, the Registrar shall provide the complainant with written notice of that fact and an expected date of disposition which shall be no more than 60 days from the date of the written notice. 2007, c. 10, Sched. M, s. 30.

If further delay

(4) If a panel has not disposed of the complaint by the expected date of disposition described in subsection (3), the Registrar shall,

(a) provide the member and complainant with written notice and reasons for the delay and the new expected date of disposition which shall be no more than 30 days from the date of the revised notice or from the expected date of disposition described in subsection (3), whichever is sooner; and

(b) provide the Board with written notice of and reasons for the delay as were provided to the member and complainant. 2007, c. 10, Sched. M, s. 30.

Powers of the Board

(5) The Board, on application of the member or the complainant, shall consider the written reasons for the delay and shall do any one of the following:

1. Direct the Inquiries, Complaints and Reports Committee to continue the investigation.
2. Make recommendations the Board considers appropriate to the Inquiries, Complaints and Reports Committee.
3. Investigate the complaint and make an order under subsection (9) within 120 days of the decision to investigate the complaint. 2007, c. 10, Sched. M, s. 30.

Board's investigatory powers

(6) In investigating a complaint under paragraph 3 of subsection (5), the Board has all the powers of a panel of the Inquiries, Complaints and Reports Committee and of the Registrar with respect to the investigation of the matter and may appoint an investigator under clause 75 (1) (c). 2007, c. 10, Sched. M, s. 30.

Continuing power of Inquiries, Complaints and Reports Committee

(7) The Inquiries, Complaints and Reports Committee may take action under section 26 at any time before the Board completes its investigation. 2007, c. 10, Sched. M, s. 30.

Same

(8) For greater certainty, if the Inquiries, Complaints and Reports Committee takes action as provided for in subsection (7), the Board no longer has jurisdiction to take action under section 26. 2007, c. 10, Sched. M, s. 30.

Powers of Board re an investigation

(9) After an investigation, the Board may do any one or more of the following:

1. Refer the matter to the Inquiries, Complaints and Reports Committee.
2. Make recommendations the Board considers appropriate to the Inquiries, Complaints and Reports Committee.
3. Require the Inquiries, Complaints and Reports Committee or a panel to do anything the Committee or a panel may do under the health profession Act and this Code except to request the Registrar to conduct an investigation. 2007, c. 10, Sched. M, s. 30.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 30 - 04/06/2009

2017, c. 11, Sched. 5, s. 15 - 30/05/2017

Powers of Board re time limits

28.1 If the Board is satisfied that no person will be unduly prejudiced, it may, on reasonable grounds, extend any time limit with respect to,

(a) a requirement, under subsection 21 (1), for a review or hearing by the Board;

(b) a request, under subsection 29 (2), for a review by the Board; or

(c) the Registrar's obligation to give to the Board, under subsection 32 (1), a record of an investigation of a complaint against a member and all relevant documents and things. 2007, c. 10, Sched. M, s. 30.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 30 - 04/06/2009

Review by Board

29 (1) Subject to section 30, the Board shall review a decision of a panel of the Inquiries, Complaints and Reports Committee if the Board receives a request under subsection (2). 2007, c. 10, Sched. M, s. 30.

Request for review

(2) The complainant or the member who is the subject of the complaint may request the Board to review a decision of a panel of the Inquiries, Complaints and Reports Committee unless the decision was,

(a) to refer an allegation of professional misconduct or incompetence to the Discipline Committee; or

(b) to refer the member to a panel of the Inquiries, Complaints and Reports Committee under section 58 for incapacity proceedings. 2007, c. 10, Sched. M, s. 30.

Time limit

(3) A request for a review may be made only within 30 days after the receipt of the notice of the right to request a review given under clause 27 (1) (c). 2007, c. 10, Sched. M, s. 30.

Limitation

(4) The Board shall not, under section 28.1, extend the time limit set out in subsection (3) for more than 60 days. 2007, c. 10, Sched. M, s. 30.

Parties

(5) The complainant and the member who is the subject of the complaint are parties to a review. 2007, c. 10, Sched. M, s. 30.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 30 - 04/06/2009

When no review

30 (1) The Board shall not review a decision if the party who requested the review withdraws the request and the other party consents. 1991, c. 18, Sched. 2, s. 30 (1).

Request in bad faith, etc.

(2) If the Board considers a request to review a decision to have been frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process, it shall give the parties notice that it intends not to proceed with the review and that the parties have a right to make written submissions within thirty days after receiving the notice. 1991, c. 18, Sched. 2, s. 30 (2); 2007, c. 10, Sched. M, s. 31 (1).

Idem

(3) If the Board is satisfied, after considering the written submissions of the parties, that a request was frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process, the Board shall not review the decision. 1991, c. 18, Sched. 2, s. 30 (3); 2007, c. 10, Sched. M, s. 31 (2).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 31 (1, 2) - 04/06/2009

Personal representative as complainant

31 A complainant's personal representative may act as the complainant for the purposes of a review of the decision by the Board if the complainant dies or becomes incapacitated. 1991, c. 18, Sched. 2, s. 31.

Record of decision to be reviewed

32 (1) If the Board is requested to review a decision, the Registrar shall give the Board, within fifteen days after the Board's request, a record of the investigation and the documents and things upon which the decision was based.

Disclosure

(2) Before reviewing a decision, the Board shall disclose to the parties everything given to it by the Registrar under subsection (1).

Exceptions

(3) The Board may refuse to disclose anything that may, in its opinion,

(a) disclose matters involving public security;

(b) undermine the integrity of the complaint investigation and review process;

(c) disclose financial or personal or other matters of such a nature that the desirability of avoiding their disclosure in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that disclosure be made;

(d) prejudice a person involved in a criminal proceeding or in a civil suit or proceeding; or

(e) jeopardize the safety of any person. 1991, c. 18, Sched. 2, s. 32.

Conduct of review

33 (1) In a review, the Board shall consider either or both of,

(a) the adequacy of the investigation conducted; or

(b) the reasonableness of the decision.

Procedure

(2) In conducting a review, the Board,

(a) shall give the party requesting the review an opportunity to comment on the matters set out in clauses (1) (a) and (b) and the other party an opportunity to respond to those comments;

(b) may require the College to send a representative;

(c) may question the parties and the representative of the College;

(d) may permit the parties to make representations with respect to issues raised by any questions asked under clause (c); and

(e) shall not allow the parties or the representative of the College to question each other. 1991, c. 18, Sched. 2, s. 33.

Procedural provisions

34 (1) The following provisions apply with necessary modifications to a review by the Board:

1. Section 43 (no communication by panel members).
2. Section 45 (hearings open).
3. Section 47 (sexual misconduct witnesses).
4. Section 50 (members of panel who participate).
5. Section 55 (release of evidence). 1991, c. 18, Sched. 2, s. 34.

Same

(2) The following provisions of the *Statutory Powers Procedure Act* also apply with necessary modifications to a review by the Board:

1. Section 4 (waiver of procedural requirement).
2. Section 4.1 (disposition of proceeding without hearing).
3. Section 5.1 (written hearings).
4. Section 5.2 (electronic hearings).
5. Section 5.3 (pre-hearing conferences).
6. Section 21 (adjournments).
7. Section 21.1 (correction of errors).
8. Section 25.1 (rules). 1998, c. 18, Sched. G, s. 16.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 16 - 01/02/1999

Powers of Board

35 (1) After conducting a review of a decision, the Board may do any one or more of the following:

1. Confirm all or part of the decision.
2. Make recommendations the Board considers appropriate to the Inquiries, Complaints and Reports Committee.
3. Require the Inquiries, Complaints and Reports Committee to do anything the Committee or a panel may do under the health profession Act and this Code except to request the Registrar to conduct an investigation. 1991, c. 18, Sched. 2, s. 35 (1); 2007, c. 10, Sched. M, s. 32 (1, 2).

Decision in writing

(2) The Board shall give its decision and reasons in writing to the parties and the Inquiries, Complaints and Reports Committee. 1991, c. 18, Sched. 2, s. 35 (2); 2007, c. 10, Sched. M, s. 32 (3).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 32 (1-3) - 04/06/2009

DISCIPLINE

Inquiries, Complaints and Reports Committee referral

36 (1) The Inquiries, Complaints and Reports Committee may refer a specified allegation of a member's professional misconduct or incompetence to the Discipline Committee. 2007, c. 10, Sched. M, s. 33 (1).

Allegations of sexual abuse

(2) In deciding whether or not to refer an allegation of the sexual abuse of a patient to the Discipline Committee, the Inquiries, Complaints and Reports Committee shall take into account any opinion, required under subsection 85.3 (5), as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future. 1993, c. 37, s. 9; 2007, c. 10, Sched. M, s. 33 (2).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 9 - 31/12/1993

2007, c. 10, Sched. M, s. 33 (1, 2) - 04/06/2009

37 REPEALED: 2017, c. 11, Sched. 5, s. 16.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 34 (1-3) - 04/06/2009

2017, c. 11, Sched. 5, s. 16 - 30/05/2017

Panel for discipline hearing

38 (1) The chair of the Discipline Committee shall select a panel from among the members of the Committee to hold a hearing of allegations of a member's professional misconduct or incompetence referred to the Committee by the Inquiries, Complaints and Reports Committee. 1991, c. 18, Sched. 2, s. 38 (1); 2007, c. 10, Sched. M, s. 35.

Composition

(2) A panel shall be composed of at least three and no more than five persons, at least two of whom shall be persons appointed to the Council by the Lieutenant Governor in Council. 1991, c. 18, Sched. 2, s. 38 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 38 (2) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 17 (1))

Composition

(2) The panel selected by the chair shall be composed in accordance with regulations made pursuant to clauses 43 (1) (p) to (s) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 17 (1).

Idem

(3) At least one of the members of a panel shall be both a member of the College and a member of the Council. 1991, c. 18, Sched. 2, s. 38 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 38 (3) of Schedule 2 to the Act is repealed. (See: 2017, c. 11, Sched. 5, s. 17 (1))

Exclusion from panel

(4) No person shall be selected for a panel who has taken part in the investigation of what is to be the subject-matter of the panel's hearing. 1991, c. 18, Sched. 2, s. 38 (4).

Quorum

(5) Three members of a panel, at least one of whom must be a member who was appointed to the Council by the Lieutenant Governor in Council, constitute a quorum. 1991, c. 18, Sched. 2, s. 38 (5).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 38 (5) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 17 (2))

Quorum

(5) Quorum for the panel shall be in accordance with regulations made pursuant to clause 43 (1) (s) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 17 (2).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 35 - 04/06/2009

2017, c. 11, Sched. 5, s. 17 (1, 2) - not in force

Panel members deemed to continue

39 A member of a panel who ceases to be a member of the Discipline Committee after a hearing of a matter has commenced before the panel shall be deemed, for the purposes of dealing with that matter, to remain a member of the panel until the final disposition of the matter. 1991, c. 18, Sched. 2, s. 39.

Amendment of notice of hearing

40 A panel may at any time permit a notice of hearing of allegations against a member to be amended to correct errors or omissions of a minor or clerical nature if it is of the opinion that it is just and equitable to do so and the panel may make any order it considers necessary to prevent prejudice to the member. 1991, c. 18, Sched. 2, s. 40.

Parties

41 The College and the member against whom allegations have been made are parties to a hearing. 1991, c. 18, Sched. 2, s. 41.

Non-party participation in hearings

41.1 (1) A panel, on application by a person who is not a party, may allow the person to participate in a hearing if,

(a) the good character, propriety of conduct or competence of the person is an issue at the hearing; or

(b) the participation of the person, would, in the opinion of the panel, be of assistance to the panel. 1993, c. 37, s. 10; 2007, c. 10, Sched. M, s. 36.

Extent of participation

(2) The panel shall determine the extent to which a person who is allowed to participate may do so and, without limiting the generality of this, the panel may allow the person to make oral or written submissions, to lead evidence and to cross examine witnesses. 1993, c. 37, s. 10.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 10 - 31/12/1993

2007, c. 10, Sched. M, s. 36 - 04/06/2009

Disclosure of evidence

42 (1) Evidence against a member is not admissible at a hearing of allegations against the member unless the member is given, at least ten days before the hearing,

(a) in the case of written or documentary evidence, an opportunity to examine the evidence;

(b) in the case of evidence of an expert, the identity of the expert and a copy of the expert's written report or, if there is no written report, a written summary of the evidence; or

(c) in the case of evidence of a witness, the identity of the witness. 1991, c. 18, Sched. 2, s. 42 (1); 1993, c. 37, s. 11.

Exception

(2) A panel may, in its discretion, allow the introduction of evidence that is inadmissible under subsection (1) and may make directions it considers necessary to ensure that the member is not prejudiced. 1991, c. 18, Sched. 2, s. 42 (2).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 11 - 31/12/1993

Disclosure of evidence

42.1 (1) Evidence of an expert led by a person other than the College is not admissible unless the person gives the College, at least ten days before the hearing, the identity of the expert and a copy of the expert's written report or, if there is no written report, a written summary of the evidence. 1993, c. 37, s. 12.

Exception

(2) A panel may, in its discretion, allow the introduction of evidence that is inadmissible under this section and may make directions it considers necessary to ensure that the College is not prejudiced. 1998, c. 18, Sched. G, s. 17.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 12 - 31/12/1993; 1998, c. 18, Sched. G, s. 17 - 01/02/1999

Production orders

42.2 (1) Where, in relation to a hearing involving allegations of a member's misconduct of a sexual nature, the member seeks an order of the panel of the Discipline Committee for the production and disclosure of a record that contains information for which there is a reasonable expectation of privacy from a person who is not a party to the hearing, any one or more of the following assertions made by the member are not sufficient on their own to establish that the record is likely relevant to an issue in the hearing or to the competence of a witness to testify:

1. That the record exists.
2. That the record relates to medical or psychiatric treatment, therapy or counselling that the complainant or a witness has received or is receiving.
3. That the record relates to the incident that is the subject-matter of the proceedings.
4. That the record may disclose a prior inconsistent statement of the complainant or a witness.
5. That the record may relate to the credibility of the complainant or a witness.

6. That the record may relate to the reliability of the testimony of the complainant or a witness merely because the complainant or witness has received or is receiving psychiatric treatment, therapy or counselling.
7. That the record may reveal allegations of sexual abuse of the complainant or a witness by a person other than the member.
8. That the record relates to the sexual activity of the complainant or a witness with any person, including the member.
9. That the record relates to the presence or absence of a recent complaint.
10. That the record relates to the sexual reputation of the complainant or a witness.
11. That the record was made close in time to a complaint or report or to the activity that forms the subject-matter of the allegation against the member. 2017, c. 11, Sched. 5, s. 18.

Same

(2) A panel of the Discipline Committee may order the person who has possession or control of the record to produce the record or part of the record if the panel is satisfied that the member has established that the record is likely relevant to an issue in the hearing or to the competence of a witness to testify in the hearing and the production of the record is necessary in the interest of justice. 2017, c. 11, Sched. 5, s. 18.

Factors to be considered

(3) In determining whether to grant an order for the production of records in accordance with this section, the panel shall consider,

(a) the regulatory nature of the proceedings;

(b) the primary purpose of the proceedings, which is to protect the public and regulate the profession in the public interest;

(c) the privacy interest of the complainant or a witness in the record sought; and

(d) the nature and purpose of the record sought in the motion. 2017, c. 11, Sched. 5, s. 18.

Standing

(4) Despite subsection 41.1 (1), the panel shall, upon the application of any person who has a privacy interest in the records referred to in subsection (1) of this section, grant the person standing on the member's motion for production of the records. 2017, c. 11, Sched. 5, s. 18.

Interpretation

(5) In subsection (1),

"allegations of a member's misconduct of a sexual nature" include, but are not limited to, allegations that the member sexually abused a patient. 2017, c. 11, Sched. 5, s. 18.

Section Amendments with date in force (d/m/y)

2017, c. 11, Sched. 5, s. 18 - 01/05/2018

No communication by panel members

43 No member of a panel holding a hearing shall communicate outside the hearing, in relation to the subject-matter of the hearing, with a party or the party's representative unless the other party has been given notice of the subject-matter of the communication and an opportunity to be present during the communication. 1991, c. 18, Sched. 2, s. 43.

Legal advice

44 If a panel obtains legal advice with respect to a hearing, it shall make the nature of the advice known to the parties and they may make submissions with respect to the advice. 1991, c. 18, Sched. 2, s. 44.

Hearings public

45 (1) A hearing shall, subject to subsection (2), be open to the public. 1991, c. 18, Sched. 2, s. 45 (1).

Exclusion of public

(2) The panel may make an order that the public be excluded from a hearing or any part of it if the panel is satisfied that,

(a) matters involving public security may be disclosed;

(b) financial or personal or other matters may be disclosed at the hearing of such a nature that the harm created by disclosure would outweigh the desirability of adhering to the principle that hearings be open to the public;

(c) a person involved in a criminal proceeding or in a civil suit or proceeding may be prejudiced; or

(d) the safety of a person may be jeopardized. 1991, c. 18, Sched. 2, s. 45 (2); 2007, c. 10, Sched. M, s. 37.

Orders preventing public disclosure

(3) In situations in which the panel may make an order that the public be excluded from a hearing, it may make orders it considers necessary to prevent the public disclosure of matters disclosed at the hearing, including orders banning the publication or broadcasting of those matters. 1991, c. 18, Sched. 2, s. 45 (3).

Public information may be disclosed

(4) No order shall be made under subsection (3) that prevents the publication of anything that is contained in the register and available to the public. 1991, c. 18, Sched. 2, s. 45 (4).

Exclusion of public

(5) The panel may make an order that the public be excluded from the part of a hearing dealing with a motion for an order under subsection (2). 1991, c. 18, Sched. 2, s. 45 (5).

Orders with respect to matters in submissions

(6) The panel may make any order necessary to prevent the public disclosure of matters disclosed in the submissions relating to any motion described in subsection (5), including prohibiting the publication or broadcasting of those matters. 1991, c. 18, Sched. 2, s. 45 (6).

Reasons for order, etc.

(7) The panel shall ensure that any order it makes under this section and its reasons are available to the public in writing. 1991, c. 18, Sched. 2, s. 45 (7).

Reconsidering of order

(8) The panel may reconsider an order made under subsection (2) or (3) at the request of any person or on its own motion. 1991, c. 18, Sched. 2, s. 45 (8).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 37 - 04/06/2009

Exception to closed hearings

46 If a panel makes an order under subsection 45 (2) wholly or partly in relation to a person, the panel may allow the person and his or her personal representative to attend the hearing and may, in its discretion, allow another person to attend if, in the opinion of the panel, to do so does not undermine the reasons for making the order and does not cause undue prejudice to a party. 2007, c. 10, Sched. M, s. 38.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 38 - 04/06/2009

Sexual misconduct witnesses

47 (1) A panel shall, on the request of a witness whose testimony is in relation to allegations of a member's misconduct of a sexual nature involving the witness, make an order that no person shall publish the identity of the witness or any information that could disclose the identity of the witness. 1991, c. 18, Sched. 2, s. 47.

Interpretation

(2) In subsection (1),

"allegations of a member's misconduct of a sexual nature" include, but are not limited to, allegations that the member sexually abused the witness when the witness was a patient of the member. 1993, c. 37, s. 13.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 13 - 31/12/1993

Transcript of hearings

48 (1) The panel holding a hearing shall ensure that,

(a) the oral evidence is recorded;

(b) copies of the transcript of the hearing are available to a party on the party's request at the party's expense; and

(c) copies of the transcript of any part of the hearing that is not the subject of an order prohibiting publication are available to any person at that person's expense.

Transcripts filed with court

(2) If a transcript of a part of a hearing that is the subject of an order prohibiting publication is filed with a court in respect of proceedings, only the court and the parties to the proceedings may examine it unless the court orders otherwise. 1991, c. 18, Sched. 2, s. 48.

Admissibility of evidence

49 Despite the *Statutory Powers Procedure Act*, nothing is admissible at a hearing that would be inadmissible in a court in a civil action and the findings of a panel shall be based exclusively on evidence admitted before it. 1991, c. 18, Sched. 2, s. 49.

Members of panel who participate

50 Only the members of a panel who were present throughout a hearing shall participate in the panel's decision. 1991, c. 18, Sched. 2, s. 50.

Professional misconduct

51 (1) A panel shall find that a member has committed an act of professional misconduct if,

(a) the member has been found guilty of an offence that is relevant to the member's suitability to practise;

(b) the governing body of another health profession in Ontario, or the governing body of a health profession in a jurisdiction other than Ontario, has found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct under this section or an act of professional misconduct as defined in the regulations;

(b.0.1) the member has failed to co-operate with the Quality Assurance Committee or any assessor appointed by that committee;

(b.1) the member has sexually abused a patient; or

(c) the member has committed an act of professional misconduct as defined in the regulations. 1991, c. 18, Sched. 2, s. 51 (1); 1993, c. 37, s. 14 (1); 2007, c. 10, Sched. M, s. 39 (1); 2017, c. 11, Sched. 5, s. 19 (1).

Orders

(2) If a panel finds a member has committed an act of professional misconduct, it may make an order doing any one or more of the following:

1. Directing the Registrar to revoke the member's certificate of registration.
2. Directing the Registrar to suspend the member's certificate of registration for a specified period of time.
3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time.
4. Requiring the member to appear before the panel to be reprimanded.
5. Requiring the member to pay a fine of not more than $35,000 to the Minister of Finance.

5.1 If the act of professional misconduct was the sexual abuse of a patient, requiring the member to reimburse the College for funding provided for that patient under the program required under section 85.7.

5.2 If the panel makes an order under paragraph 5.1, requiring the member to post security acceptable to the College to guarantee the payment of any amounts the member may be required to reimburse under the order under paragraph 5.1. 1991, c. 18, Sched. 2, s. 51 (2); 1993, c. 37, s. 14 (2).

Idem

(3) In making an order under paragraph 2 or 3 of subsection (2), a panel may specify criteria to be satisfied for the removal of a suspension or the removal of terms, conditions and limitations imposed on a member's certificate of registration. 1991, c. 18, Sched. 2, s. 51 (3).

Suspension of order

(4) A panel may suspend the effect of all or part of an order made under subsection (2) for a specified period and on specified conditions. 1991, c. 18, Sched. 2, s. 51 (4); 2007, c. 10, Sched. M, s. 39 (2).

No gender-based terms, conditions, limitations

(4.1) In making an order under paragraph 3 of subsection (2), a panel shall not make any order directing the Registrar to impose any gender-based terms, conditions or limitations on a member's certificate of registration. 2017, c. 11, Sched. 5, s. 19 (2).

Interim suspension of certificate

(4.2) The panel shall immediately make an interim order suspending a member's certificate of registration until such time as the panel makes an order under subsection (5) or (5.2) if the panel finds that the member has committed an act of professional misconduct,

(a) under clause (1) (a) and the offence is prescribed for the purposes of clause (5.2) (a) in a regulation made under clause 43 (1) (v) of the *Regulated Health Professions Act, 1991*;

(b) under clause (1) (b) and the misconduct includes or consists of any of the conduct listed in paragraph 3 of subsection (5); or

(c) by sexually abusing a patient and the sexual abuse involves conduct listed under subparagraphs 3 i to vii of subsection (5). 2017, c. 11, Sched. 5, s. 19 (2).

Non-application to mandatory orders

(4.3) For greater certainty, subsection (4) does not apply to a mandatory order made under subsection (5) or a mandatory order made under subsection (5.2). 2017, c. 11, Sched. 5, s. 19 (2).

Orders relating to sexual abuse

(5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.

2. Suspend the member's certificate of registration if the sexual abuse does not consist of or include conduct listed in paragraph 3 and the panel has not otherwise made an order revoking the member's certificate of registration under subsection (2).
3. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:
    i. Sexual intercourse.
    ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.
    iii. Masturbation of the member by, or in the presence of, the patient.
    iv. Masturbation of the patient by the member.
    v. Encouraging the patient to masturbate in the presence of the member.
    vi. Touching of a sexual nature of the patient's genitals, anus, breasts or buttocks.
    vii. Other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 19 (3).

Interpretation

(5.1) For greater certainty, for the purposes of subsection (5),

"sexual nature" does not include touching or conduct of a clinical nature appropriate to the service provided. 2017, c. 11, Sched. 5, s. 19 (3).

Mandatory revocation

(5.2) The panel shall, in addition to anything else the panel may do under subsection (2), reprimand the member and revoke the member's certificate of registration if,

(a) the member has been found guilty of professional misconduct under clause (1) (a) and the offence is prescribed in a regulation made under clause 43 (1) (v) of the *Regulated Health Professions Act, 1991*; or

(b) the member has been found guilty of professional misconduct under clause (1) (b) and the misconduct includes or consists of any of the conduct listed in paragraph 3 of subsection (5). 2017, c. 11, Sched. 5, s. 19 (3).

Statement re impact of sexual abuse

(6) Before making an order under subsection (5), the panel shall consider any written statement that has been filed, and any oral statement that has been made to the panel, describing the impact of the sexual abuse on the patient. 1993, c. 37, s. 14 (3).

Same

(7) The statement may be made by the patient or by his or her representative. 1993, c. 37, s. 14 (3).

Same

(8) The panel shall not consider the statement unless a finding of professional misconduct has been made. 1993, c. 37, s. 14 (3).

Notice to member

(9) When a written statement is filed, the panel shall, as soon as possible, have copies of it provided to the member, to his or her counsel and to the College. 1993, c. 37, s. 14 (3).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 14 (1-3) - 31/12/1993

2007, c. 10, Sched. M, s. 39 (1, 2) - 04/06/2009

2017, c. 11, Sched. 5, s. 19 (1-3) - 30/05/2017

Incompetence

52 (1) A panel shall find a member to be incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted. 1991, c. 18, Sched. 2, s. 52 (1); 2007, c. 10, Sched. M, s. 40 (1).

Order

(2) If a panel finds a member is incompetent, it may make an order doing any one or more of the following:

1. Directing the Registrar to revoke the member's certificate of registration.
2. Directing the Registrar to suspend the member's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified period of time or indefinite period of time. 1991, c. 18, Sched. 2, s. 52 (2); 2007, c. 10, Sched. M, s. 40 (2).

Idem

(3) In making an order under paragraph 2 or 3 of subsection (2), a panel may specify criteria to be satisfied for the removal of a suspension or the removal of terms, conditions and limitations imposed on a member's certificate of registration. 1991, c. 18, Sched. 2, s. 52 (3); 2007, c. 10, Sched. M, s. 40 (3).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 40 (1-3) - 04/06/2009

Costs if proceedings unwarranted

53 If a panel is of the opinion that the commencement of proceedings was unwarranted, it may make an order requiring the College to pay all or part of the member's legal costs. 1991, c. 18, Sched. 2, s. 53.

College's costs

53.1 In an appropriate case, a panel may make an order requiring a member who the panel finds has committed an act of professional misconduct or finds to be incompetent to pay all or part of the following costs and expenses:

1. The College's legal costs and expenses.
2. The College's costs and expenses incurred in investigating the matter.
3. The College's costs and expenses incurred in conducting the hearing. 1993, c. 37, s. 15.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 15 - 31/12/1993

Decision to complainant

54 A panel shall give its decision and reasons in writing to the parties and, if the matter had been referred to the Discipline Committee by the Inquiries, Complaints and Reports Committee, to the complainant in the matter. 1991, c. 18, Sched. 2, s. 54; 2007, c. 10, Sched. M, s. 41.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 41 - 04/06/2009

Release of evidence

55 The Discipline Committee shall release documents and things put into evidence at a hearing to the person who produced them, on request, within a reasonable time after the matter in issue has been finally determined. 1991, c. 18, Sched. 2, s. 55.

Publication of decisions

56 (1) The College shall publish a panel's decision and its reasons, or a summary of its reasons, in its annual report and may publish the decision and reasons or summary in any other publication of the College.

Publication of member's name

(2) In publishing a decision and reasons or summary under subsection (1), the College shall publish the name of the member who was the subject of the proceeding if,

(a) the results of the proceeding may be obtained by a person from the register; or

(b) the member requests the publication of his or her name.

Withholding of member's name

(3) The College shall not publish the member's name unless it is required to do so under subsection (2). 1991, c. 18, Sched. 2, s. 56.

INCAPACITY

Registrar's inquiry

57 If the Registrar believes that a member may be incapacitated, the Registrar shall make inquiries he or she considers appropriate and shall report the results of the inquiries to the Inquiries, Complaints and Reports Committee. 1991, c. 18, Sched. 2, s. 57; 2007, c. 10, Sched. M, s. 42.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 42 - 04/06/2009

Panel shall inquire

58 (1) A panel selected by the chair of the Inquiries, Complaints and Reports Committee from among the members of the Committee shall inquire into whether a member is incapacitated if,

(a) the Inquiries, Complaints and Reports Committee receives a report from the Registrar under section 57; or

(b) a referral is made from a panel of the Inquiries, Complaints and Reports Committee under paragraph 2 of subsection 26 (1). 2007, c. 10, Sched. M, s. 43.

Notice to member

(2) The Inquiries, Complaints and Reports Committee shall give a member notice that it intends to inquire into whether the member is incapacitated. 2007, c. 10, Sched. M, s. 43.

Transitional

(3) A board of inquiry that was constituted under this section, as it existed immediately before the coming into force of section 43 of Schedule M to the *Health System Improvements Act, 2007*, shall be deemed to continue to be validly constituted and to have the authority to do anything that it could have done before the coming into force of section 44 of that Schedule, and where the board of inquiry was to give a copy of a report to the Executive Committee, that Committee may continue to act with respect to that matter and shall have the authority to do anything it could have done before the coming into force of sections 44 to 47 of that Schedule. 2007, c. 10, Sched. M, s. 43.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 43 - 04/06/2009

Inquiries by panel

59 (1) A panel shall make the inquiries it considers appropriate. 2007, c. 10, Sched. M, s. 44.

Physical or mental examinations

(2) If, after making inquiries, a panel has reasonable and probable grounds to believe that the member who is the subject of the inquiry is incapacitated, the panel may require the member to submit to physical or mental examinations conducted or ordered by a health professional

specified by the panel and may, subject to section 63, make an order directing the Registrar to suspend the member's certificate of registration until he or she submits to the examinations. 2007, c. 10, Sched. M, s. 44.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 44 - 04/06/2009

Panel's report

60 The panel shall give a copy of its report and a copy of any report on an examination required under subsection 59 (2) to the member who was the subject of the inquiry. 2007, c. 10, Sched. M, s. 44.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 44 - 04/06/2009

Referral to Fitness to Practise Committee

61 After giving a copy of its report and copy of any report on an examination required under subsection 59 (2) to the member, the panel may refer the matter to the Fitness to Practise Committee. 2007, c. 10, Sched. M, s. 44.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 44 - 04/06/2009

Interim suspension

62 (1) The panel may, subject to section 63, make an interim order directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration if it is of the opinion that the physical or mental state of the member exposes or is likely to expose his or her patients to harm or injury. 2017, c. 11, Sched. 5, s. 20.

No gender-based terms

(2) Despite subsection (1), the panel shall not make an interim order directing the Registrar to impose any gender-based terms, conditions or limitations on a member's certificate of registration. 2017, c. 11, Sched. 5, s. 20.

Procedure following interim suspension

(3) If an order is made under subsection (1) in relation to a matter,

(a) the College shall inquire into and prosecute the matter expeditiously; and

(b) the Inquiries, Complaints and Reports Committee and the Fitness to Practise Committee shall give precedence to the matter. 2017, c. 11, Sched. 5, s. 20.

Duration of order

(4) An order under subsection (1) continues in force until it is varied by the panel of the Inquiries, Complaints and Reports Committee or until the matter is finally disposed of by a panel of the Inquiries, Complaints and Reports Committee or the Fitness to Practise Committee. 2017, c. 11, Sched. 5, s. 20.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 45 (1, 2) - 04/06/2009

2017, c. 11, Sched. 5, s. 20 - 30/05/2017

Restrictions on orders

63 (1) No order shall be made with respect to a member under subsection 59 (2) or subsection 62 (1) unless the member has been given,

(a) notice of the intention to make the order;

(b) at least 14 days to make written submissions to the panel; and

(c) in the case of an order under subsection 62 (1), a copy of the provisions of section 62. 2017, c. 11, Sched. 5, s. 21.

Extraordinary action to protect the public

(2) Despite subsection (1), an order may be made without notice to the member, subject to the right of the member to make submissions while the suspension is in place to the panel that made the order, if the panel is of the opinion on reasonable and probable grounds that the physical or mental state of the member exposes or is likely to expose his or her patients to harm or injury and urgent intervention is needed. 2007, c. 10, Sched. M, s. 46.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 46 - 04/06/2009

2017, c. 11, Sched. 5, s. 21 - 30/05/2017

Panels for Fitness to Practise hearings

64 (1) The chair of the Fitness to Practise Committee shall select a panel from among the members of the Committee to hold a hearing of any matter referred to the Committee by a panel of the Inquiries, Complaints and Reports Committee. 1991, c. 18, Sched. 2, s. 64 (1); 2007, c. 10, Sched. M, s. 47 (1).

Composition

(2) A panel shall be composed of at least three persons, at least one of whom shall be a person appointed to the Council by the Lieutenant Governor in Council. 1991, c. 18, Sched. 2, s. 64 (2); 2007, c. 10, Sched. M, s. 47 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 64 (2) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 22)

Composition of panels

(2) The panel selected by the chair shall be composed in accordance with regulations made pursuant to clauses 43 (1) (p) to (s) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 22.

Quorum

(3) Three members of a panel constitute a quorum. 1991, c. 18, Sched. 2, s. 64 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 64 (3) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 22)

Quorum

(3) Quorum for the panel shall be in accordance with regulations made pursuant to clause 43 (1) (s) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 22.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 47 (1, 2) - 04/06/2009

2017, c. 11, Sched. 5, s. 22 - not in force

Parties

65 The College, the member who is alleged to be incapacitated and any other person specified by the panel are parties to a hearing. 1991, c. 18, Sched. 2, s. 65.

Reports of health professionals

66 (1) A report prepared and signed by a health professional containing his or her findings and the facts upon which they are based is admissible as evidence at a hearing without proof of its making or of the health professional's signature if the party introducing the report gives the other parties a copy of the report at least ten days before the hearing.

Testimony of health professionals

(2) A health professional may not give evidence in his or her professional capacity at a hearing unless a report, prepared and signed by the health professional containing his or her findings and the facts upon which they are based, is introduced as evidence.

Cross-examination

(3) If a report described in subsection (1) is introduced by a party, the other parties may summon and cross-examine the person who prepared the report. 1991, c. 18, Sched. 2, s. 66.

Exception

(4) A panel may, in its discretion, allow a party to introduce evidence that is inadmissible under this section and may make directions it considers necessary to ensure that the other parties are not prejudiced. 1998, c. 18, Sched. G, s. 18.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 18 - 01/02/1999

Procedural provisions

67 The following provisions apply with necessary modifications to a hearing by a panel of the Fitness to Practise Committee:

1. Subsection 22 (4) (findings of fact).
2. Subsection 38 (4) (exclusion from panel).
3. Section 39 (panel members deemed to continue).
4. Section 42 (disclosure of evidence).

4.1 Section 42.1 (disclosure of evidence by member).

5. Section 43 (no communication by panel members).
6. Section 44 (legal advice).
7. Section 47 (sexual misconduct witnesses).
8. Section 50 (members of panel who participate).
9. Section 55 (release of evidence). 1991, c. 18, Sched. 2, s. 67; 1993, c. 37, s. 16; 2007, c. 10, Sched. M, s. 48.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 16 - 31/12/1993

2007, c. 10, Sched. M, s. 48 - 04/06/2009

Hearings closed

68 (1) A hearing by a panel of the Fitness to Practise Committee shall, subject to subsection (2), be closed to the public. 1991, c. 18, Sched. 2, s. 68 (1); 2007, c. 10, Sched. M, s. 49 (1).

Open on request of member in some cases

(2) A hearing shall be open to the public if the person who is alleged to be incapacitated requests it in a written notice received by the Registrar before the day the hearing commences, unless the panel is satisfied that,

(a) matters involving public security may be disclosed;

(b) financial or personal matters or other matters may be disclosed at the hearing of such a nature that the harm created by disclosure would outweigh the desirability of adhering to the principle that hearings be open to the public;

(c) a person involved in a criminal proceeding or civil suit may be prejudiced; or

(d) the safety of any person may be jeopardized. 1991, c. 18, Sched. 2, s. 68 (2); 2007, c. 10, Sched. M, s. 49 (2).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 49 (1, 2) - 04/06/2009

Orders

69 (1) If a panel finds that a member is incapacitated, it shall make an order doing any one or more of the following:

1. Directing the Registrar to revoke the member's certificate of registration.
2. Directing the Registrar to suspend the member's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified period of time or indefinite period of time. 1991, c. 18, Sched. 2, s. 69 (1); 2007, c. 10, Sched. M, s. 50 (1).

Idem

(2) In making an order under paragraph 2 or 3 of subsection (1), a panel may specify criteria to be satisfied for the removal of a suspension or the removal of terms, conditions and limitations imposed on a member's certificate of registration. 1991, c. 18, Sched. 2, s. 69 (2); 2007, c. 10, Sched. M, s. 50 (2).

Varying

(3) A member or the College may apply to the Fitness to Practise Committee for an order directing the Registrar to remove or modify any term, condition or limitation imposed on the member's certificate of registration as a result of paragraph 3 of subsection (1) and the chair may select a panel to deal with the application. 2007, c. 10, Sched. M, s. 50 (3).

Limitations

(4) The right to apply under subsection (3) is subject to any limitation in the order or to which the member consented and to any limitation made under subsection (5) in the disposition of a previous application to vary. 2007, c. 10, Sched. M, s. 50 (3).

Limitations on applications

(5) The panel, in disposing of an application by a member under subsection (3), may fix a period of time not longer than six months during which the member may not make a further application. 2007, c. 10, Sched. M, s. 50 (3).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 50 (1-3) - 04/06/2009

APPEALS TO COURT

Appeals from decisions

70 (1) A party to proceedings before the Board concerning a registration hearing or review or to proceedings before a panel of the Discipline or Fitness to Practise Committee, other than a hearing of an application under subsection 72 (1), may appeal from the decision of the Board or panel to the Divisional Court.

Basis of appeal

(2) An appeal under subsection (1) may be made on questions of law or fact or both.

Court's powers

(3) In an appeal under subsection (1), the Court has all the powers of the panel that dealt with the matter and, in an appeal from the Board, the Court also has all the powers of the Board. 1991, c. 18, Sched. 2, s. 70.

No stay of certain orders pending appeal

71 An order made by a panel of the Discipline Committee on the grounds of incompetence or by a panel of the Fitness to Practise Committee on the grounds of incapacity, directing the Registrar to revoke, suspend or impose terms, limitations or conditions on a member's certificate, takes effect immediately despite any appeal. 1991, c. 18, Sched. 2, s. 71.

No stay of certain orders pending appeal

71.1 Section 71 also applies to an order made by a panel of the Discipline Committee because of a finding that a member has committed sexual abuse of the kind described in paragraph 3 of subsection 51 (5) or an act of professional misconduct described in subsection 51 (5.2). 2017, c. 11, Sched. 5, s. 23.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 17 - 31/12/1993

2017, c. 11, Sched. 5, s. 23 - 30/05/2017

Order where public at risk

71.2 If the conduct of the member exposes or is likely to expose his or her patients to harm or injury and urgent intervention is needed, the College may apply to a judge of the Superior Court of Justice for an order declaring that an order that was made by a panel of the Discipline Committee on the grounds of professional misconduct and that directs the Registrar to revoke, suspend or impose terms, conditions or limitations on a member's certificate shall take effect immediately despite any appeal and any other Act. 2007, c. 10, Sched. M, s. 51.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 51 - 04/06/2009

REINSTATEMENT

Applications for reinstatement

72 (1) A person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings may apply in writing to the Registrar to have a new certificate issued or the suspension removed. 1991, c. 18, Sched. 2, s. 72 (1).

Time of application

(2) An application under subsection (1) shall not be made earlier than,

(a) one year after the date on which the certificate of registration was revoked or suspended; or

(b) six months after a decision has been made in a previous application under subsection (1). 2007, c. 10, Sched. M, s. 52.

Time of application, sexual abuse cases

(3) An application under subsection (1), in relation to a revocation for sexual abuse of a patient, shall not be made earlier than,

(a) five years after the date on which the certificate of registration was revoked; or

(b) six months after a decision has been made in a previous application under subsection (1). 2007, c. 10, Sched. M, s. 52.

Notice where complainant

(4) The Registrar shall give the complainant in the original proceeding notice of an application under subsection (1). 2007, c. 10, Sched. M, s. 52.

Reasons for reinstatement

(5) The person making the application under subsection (1) shall provide reasons why the certificate should be issued or the suspension be removed. 2007, c. 10, Sched. M, s. 52.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 18 - 31/12/1993

2007, c. 10, Sched. M, s. 52 - 04/06/2009

Referral to Committee

73 (1) The Registrar shall refer the application, if the revocation or suspension was on the grounds of,

(a) professional misconduct or incompetence, to the Discipline Committee; or

(b) incapacity, to the Fitness to Practise Committee.

Hearings

(2) The chair of a committee to which an application is referred shall select a panel from among the members of the committee to hold a hearing of the application.

Procedural provisions

(3) The following provisions apply with necessary modifications to a hearing of an application by a panel of the Discipline Committee:

1. Subsection 22 (4) (findings of fact).
2. Subsection 38 (2) (composition).
3. Subsection 38 (3) (composition).

Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 3 of subsection 73 (3) of Schedule 2 to the Act is repealed. (See: 2017, c. 11, Sched. 5, s. 24)

4. Subsection 38 (5) (quorum).
5. Section 43 (no communication by panel members).
6. Section 44 (legal advice).
7. Section 45 (hearings open).
8. Section 47 (sexual misconduct witnesses).
9. Section 48 (transcript of hearings).
10. Section 50 (members of panel who participate).
11. Section 55 (release of evidence).

Idem

(4) The following provisions apply with necessary modifications to a hearing of an application by a panel of the Fitness to Practise Committee:

1. Subsection 22 (4) (findings of fact).
2. Section 43 (no communication by panel members).
3. Section 44 (legal advice).
4. Section 47 (sexual misconduct witnesses).
5. Section 48 (transcript of hearings).
6. Section 50 (members of panel who participate).
7. Section 55 (release of evidence).
8. Subsection 64 (2) (composition).
9. Subsection 64 (3) (quorum).
10. Section 68 (hearings closed).

Order

(5) A panel may, after a hearing, make an order doing any one or more of the following:

1. Directing the Registrar to issue a certificate of registration to the applicant.
2. Directing the Registrar to remove the suspension of the applicant’s certificate of registration.

3. Directing the Registrar to impose specified terms, conditions and limitations on the applicant's certificate of registration. 1991, c. 18, Sched. 2, s. 73 (1-5).

Limitation for sexual abuse cases

(5.1) A panel may not make an order directing that the Registrar issue a new certificate of registration to an applicant whose certificate had been revoked for sexual abuse of a patient unless the prescribed conditions are met. 1993, c. 37, s. 19.

Decision

(6) A panel that held a hearing of an application shall give its decision and reasons in writing to the applicant and the Registrar. 1991, c. 18, Sched. 2, s. 73 (6).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 19 - 31/12/1993

2017, c. 11, Sched. 5, s. 24 - not in force

Orders without hearing

74 (1) The Council or Executive Committee may, without a hearing, with respect to a person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings, make an order doing any one or more of the following:

1. Directing the Registrar to issue a new certificate of registration to the applicant.
2. Directing the Registrar to remove the suspension of the applicant's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the applicant's certificate of registration if an order is made under paragraph 1 or 2. 1991, c. 18, Sched. 2, s. 74.

Limitation

(2) This section does not apply with respect to a revocation for sexual abuse of a patient. 1993, c. 37, s. 20.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 20 - 31/12/1993

REGISTRAR'S POWERS OF INVESTIGATION

Investigators

75 (1) The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if,

(a) the Registrar believes on reasonable and probable grounds that the member has committed an act of professional misconduct or is incompetent and the Inquiries, Complaints and Reports Committee approves of the appointment;

(b) the Inquiries, Complaints and Reports Committee has received information about a member from the Quality Assurance Committee under paragraph 4 of subsection 80.2 (1) and has requested the Registrar to conduct an investigation; or

(c) the Inquiries, Complaints and Reports Committee has received a written complaint about the member and has requested the Registrar to conduct an investigation. 2007, c. 10, Sched. M, s. 53.

Emergencies

(2) The Registrar may appoint an investigator if,

(a) the Registrar believes on reasonable and probable grounds that the conduct of the member exposes or is likely to expose his or her patients to harm or injury, and that the investigator should be appointed immediately; and

(b) there is not time to seek approval from the Inquiries, Complaints and Reports Committee. 2007, c. 10, Sched. M, s. 53.

Report

(3) Where an investigator has been appointed under subsection (2), the Registrar shall report the appointment of the investigator to the Inquiries, Complaints and Reports Committee within five days. 2007, c. 10, Sched. M, s. 53.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 53 - 04/06/2009

Application of *Public Inquiries Act, 2009*

76 (1) An investigator may inquire into and examine the practice of the member to be investigated and section 33 of the *Public Inquiries Act, 2009* applies to that inquiry and examination. 2009, c. 33, Sched. 6, s. 84.

Reasonable inquiries

(1.1) An investigator may make reasonable inquiries of any person, including the member who is the subject of the investigation, on matters relevant to the investigation. 2009, c. 6, s. 1.

Idem

(2) An investigator may, on the production of his or her appointment, enter at any reasonable time the place of practice of the member and may examine anything found there that is relevant to the investigation. 1991, c. 18, Sched. 2, s. 76 (2); 2007, c. 10, Sched. M, s. 54.

Obstruction prohibited

(3) No person shall obstruct an investigator or withhold or conceal from him or her or destroy anything that is relevant to the investigation. 1991, c. 18, Sched. 2, s. 76 (3).

Member to co-operate

(3.1) A member shall co-operate fully with an investigator. 2009, c. 6, s. 1.

Conflicts

(4) This section applies despite any provision in any Act relating to the confidentiality of health records. 1991, c. 18, Sched. 2, s. 76 (4).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 54 - 04/06/2007

2009, c. 6, s. 1 - 23/04/2009

2009, c. 33, Sched. 6, s. 84 - 01/06/2011

Entries and searches

77 (1) A justice of the peace may, on the application of the investigator made without notice, issue a warrant authorizing an investigator to enter and search a place and examine any document or thing specified in the warrant if the justice of the peace is satisfied that the investigator has been properly appointed and that there are reasonable and probable grounds established upon oath for believing that,

(a) the member being investigated has committed an act of professional misconduct or is incompetent; and

(b) there is something relevant to the investigation at the place. 2007, c. 10, Sched. M, s. 55.

Hours of execution

(2) A warrant issued under subsection (1) may be executed only between 8 a.m. and 8 p.m. unless the warrant specifies otherwise. 2007, c. 10, Sched. M, s. 55.

Application for dwelling

(2.1) An application for a warrant under subsection (1) to enter a dwelling shall specifically indicate that the application relates to a dwelling. 2007, c. 10, Sched. M, s. 55.

Assistance and entry by force

(3) An investigator entering and searching a place under the authority of a warrant issued under subsection (1) may be assisted by other persons and may enter a place by force. 1991, c. 18, Sched. 2, s. 77 (3).

Investigator to show identification

(4) An investigator entering and searching a place under the authority of a warrant issued under subsection (1) shall produce his or her identification, on request, to any person at the place. 1991, c. 18, Sched. 2, s. 77 (4).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 55 - 04/06/2007

Copying of documents and objects

78 (1) An investigator may copy, at the College's expense, a document or object that an investigator may examine under subsection 76 (2) or under the authority of a warrant issued under subsection 77 (1).

Removal for documents and objects

(2) An investigator may remove a document or object described in subsection (1) if,

(a) it is not practicable to copy it in the place where it is examined; or

(b) a copy of it is not sufficient for the purposes of the investigation.

Return of documents and objects or copies

(3) If it is practicable to copy a document or object removed under subsection (2), the investigator shall,

(a) if it was removed under clause (2) (a), return the document or object within a reasonable time; or

(b) if it was removed under clause (2) (b), provide the person who was in possession of the document or object with a copy of it within a reasonable time.

Copy as evidence

(4) A copy of a document or object certified by an investigator to be a true copy shall be received in evidence in any proceeding to the same extent and shall have the same evidentiary value as the document or object itself.

Definition

(5) In this section,

"document" means a record of information in any form and includes any part of it. 1991, c. 18, Sched. 2, s. 78.

Report of investigation

79 The Registrar shall report the results of an investigation to,

(a) the Inquiries, Complaints and Reports Committee if the investigator was appointed under clause 75 (1) (a) or (b) or subsection 75 (2);

(b) the Inquiries, Complaints and Reports Committee if the investigator was appointed under clause 75 (1) (c), at the request of the Inquiries, Complaints and Reports Committee; or

(c) the Board if the investigator was appointed under clause 75 (1) (c) by the Board exercising the Registrar's powers under subsection 28 (6). 2007, c. 10, Sched. M, s. 56.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 56 - 04/06/2009

QUALITY ASSURANCE COMMITTEE

79.1 REPEALED: 2007, c. 10, Sched. M, s. 57.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 21 - 31/12/1993

2007, c. 10, Sched. M, s. 57 - 04/06/2009

Quality assurance program required

80 The Council shall make regulations under clause 95 (1) (r) prescribing a quality assurance program. 1991, c. 18, Sched. 2, s. 80; 2000, c. 26, Sched. H, s. 3 (1).

Section Amendments with date in force (d/m/y)

2000, c. 26, Sched. H, s. 3 (1) - 06/12/2000

Minimum requirements for quality assurance program

80.1 A quality assurance program prescribed under section 80 shall include,

(a) continuing education or professional development designed to,

(i) promote continuing competence and continuing quality improvement among the members,

Note: On a day to be named by proclamation of the Lieutenant Governor, clause (a) is amended by adding the following subclause:

(i.1) promote interprofessional collaboration,

See: 2009, c. 26, ss. 24 (14), 27 (2).

(ii) address changes in practice environments, and

(iii) incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council;

(b) self, peer and practice assessments; and

(c) a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program. 2007, c. 10, Sched. M, s. 58.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 58 - 04/06/2009

2009, c. 26, s. 24 (14) - not in force

Powers of the Committee

80.2 (1) The Quality Assurance Committee may do only one or more of the following:

1. Require individual members whose knowledge, skill and judgment have been assessed under section 82 and found to be unsatisfactory to participate in specified continuing education or remediation programs.
2. Direct the Registrar to impose terms, conditions or limitations for a specified period to be determined by the Committee on the certificate of registration of a member,
   i. whose knowledge, skill and judgment have been assessed or reassessed under section 82 and have been found to be unsatisfactory, or
   ii. who has been directed to participate in specified continuing education or remediation programs as required by the Committee under paragraph 1 and has not completed those programs successfully.
3. Direct the Registrar to remove terms, conditions or limitations before the end of the specified period, if the Committee is satisfied that the member's knowledge, skill and judgment are now satisfactory.
4. Disclose the name of the member and allegations against the member to the Inquiries, Complaints and Reports Committee if the Quality Assurance Committee is of the opinion that the member may have committed an act of professional misconduct, or may be incompetent or incapacitated. 2007, c. 10, Sched. M, s. 58.

Notice

(2) No direction shall be given to the Registrar under paragraph 2 of subsection (1) unless the member has been given notice of the Quality Assurance Committee's intention to give direction, and at least 14 days to make written submissions to the Committee. 2007, c. 10, Sched. M, s. 58.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 58 - 04/06/2009

Assessors

81 The Quality Assurance Committee may appoint assessors for the purposes of a quality assurance program. 1991, c. 18, Sched. 2, s. 81.

Co-operation with Committee and assessors

82 (1) Every member shall co-operate with the Quality Assurance Committee and with any assessor it appoints and in particular every member shall,

(a) permit the assessor to enter and inspect the premises where the member practises;

(b) permit the assessor to inspect the member's records of the care of patients;

(c) give the Committee or the assessor the information in respect of the care of patients or in respect of the member's records of the care of patients the Committee or assessor requests in the form the Committee or assessor specifies;

(d) confer with the Committee or the assessor if requested to do so by either of them; and

(e) participate in a program designed to evaluate the knowledge, skill and judgment of the member, if requested to do so by the Committee.

Inspection of premises

(2) Every person who controls premises where a member practises, other than a private dwelling, shall allow an assessor to enter and inspect the premises.

Inspection of records

(3) Every person who controls records relating to a member's care of patients shall allow an assessor to inspect the records.

Exception

(4) Subsection (3) does not require a patient or his or her representative to allow an assessor to inspect records relating to the patient's care.

Conflict

(5) This section applies despite any provision in any Act relating to the confidentiality of health records. 1991, c. 18, Sched. 2, s. 82.

Confidentiality of information

83 (1) Except as provided in section 80.2 and in this section, the Quality Assurance Committee and any assessor appointed by it shall not disclose, to any other committee, information that,

(a) was given by the member; or

(b) relates to the member and was obtained under section 82. 1991, c. 18, Sched. 2, s. 83 (1); 2007, c. 10, Sched. M, s. 59 (1).

Exception if member gave false information

(2) Where relevant to a proceeding before a committee, information described in subsection (1) may be disclosed to that committee for the purpose of showing that the member knowingly gave false information to the Quality Assurance Committee or an assessor. 2007, c. 10, Sched. M, s. 59 (2).

(3) REPEALED: 2007, c. 10, Sched. M, s. 59 (3).

Use in other Committees

(4) Information that was disclosed contrary to subsection (1) shall not be used against the member to whom it relates in a proceeding before the Discipline or Fitness to Practise Committees. 1991, c. 18, Sched. 2, s. 83 (4).

(5) REPEALED: 2004, c. 3, Sched. B, s. 11 (1).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 19 - 01/02/1999

2004, c. 3, Sched. B, s. 11 (1) - 01/11/2004

2007, c. 10, Sched. M, s. 59 (1-3) - 04/06/2009

Quality assurance and other information

83.1 (1) In this section,

"disclose" means, with respect to quality assurance information, to provide or make the information available to a person who is not,

(a) a member of the Quality Assurance Committee,

(b) an assessor appointed by the Committee, a person engaged on its behalf such as a mentor or a person conducting an assessment program on its behalf, or

(c) a person providing administrative support to the Committee or the Registrar or the Committee's legal counsel,

and "disclosure" has a corresponding meaning; ("divulguer", "divulgation")

"proceeding" includes a proceeding that is within the jurisdiction of the Legislature and that is held in, before or under the rules of a court, a tribunal, a commission, a justice of the peace, a coroner, a committee of a College under the *Regulated Health Professions Act, 1991*, a committee of the Board under the *Drugless Practitioners Act*, a committee of the College under the *Social Work and Social Service Work Act, 1998*, an arbitrator or a mediator, but does not include any activities carried on by the Quality Assurance Committee; ("instance")

"quality assurance information" means information that,

(a) is collected by or prepared for the Quality Assurance Committee for the sole or primary purpose of assisting the Committee in carrying out its functions,

(b) relates solely or primarily to any activity that the Quality Assurance Committee carries on as part of its functions,

(c) is prepared by a member or on behalf of a member solely or primarily for the purpose of complying with the requirements of the prescribed quality assurance program, or

(d) is provided to the Quality Assurance Committee under subsection (3),

but does not include,

(e) the name of a member and allegations that the member may have committed an act of professional misconduct, or may be incompetent or incapacitated,

(f) information that was referred to the Quality Assurance Committee from another committee of the College or the Board, or

(g) information that a regulation made under this Code specifies is not quality assurance information and that the Quality Assurance Committee receives after the day on which that regulation is made; ("renseignements sur l'assurance de la qualité")

"witness" means a person, whether or not a party to a proceeding, who, in the course of the proceeding,

(a) is examined or cross-examined for discovery, either orally or in writing,

(b) makes an affidavit, or

(c) is competent or compellable to be examined or cross-examined or to produce a document, whether under oath or not. (“témoin”) 2004, c. 3, Sched. B, s. 11 (2).

Conflict

(2) In the event of a conflict between this section and a provision under any other Act, this section prevails unless it specifically provides otherwise. 2004, c. 3, Sched. B, s. 11 (2).

Disclosure to Quality Assurance Committee

(3) Despite the *Personal Health Information Protection Act, 2004*, a person may disclose any information to the Quality Assurance Committee for the purposes of the committee. 2004, c. 3, Sched. B, s. 11 (2).

Quality assurance information

(4) Despite the *Personal Health Information Protection Act, 2004*, no person shall disclose quality assurance information except as permitted by the *Regulated Health Professions Act, 1991*, including this Code or an Act named in Schedule 1 to that Act or regulations or by-laws made under the *Regulated Health Professions Act, 1991* or under an Act named in Schedule 1 to that Act. 2004, c. 3, Sched. B, s. 11 (2).

Non-disclosure in proceeding

(5) No person shall ask a witness and no court or other body conducting a proceeding shall permit or require a witness in the proceeding to disclose quality assurance information except as permitted or required by the provisions relating to the quality assurance program. 2004, c. 3, Sched. B, s. 11 (2).

Non-admissibility of evidence

(6) Quality assurance information is not admissible in evidence in a proceeding. 2004, c. 3, Sched. B, s. 11 (2).

Non-retaliation

(7) No one shall dismiss, suspend, demote, discipline, harass or otherwise disadvantage a person by reason that the person has disclosed information to the Quality Assurance Committee under subsection (3), but a person may be disciplined for disclosing false information to the Committee. 2004, c. 3, Sched. B, s. 11 (2).

Immunity

(8) No action or other proceeding may be instituted against a person who in good faith discloses information to a Quality Assurance Committee at the request of the Committee or for the purposes of assisting the Committee in carrying out its functions. 2004, c. 3, Sched. B, s. 11 (2).

Section Amendments with date in force (d/m/y)

2004, c. 3, Sched. B, s. 11 (2) - 01/11/2004

PATIENT RELATIONS PROGRAM

Patient relations program

84 (1) The College shall have a patient relations program. 1991, c. 18, Sched. 2, s. 84 (1).

Measures for sexual abuse of patients

(2) The patient relations program must include measures for preventing and dealing with sexual abuse of patients. 1993, c. 37, s. 22 (1); 2007, c. 10, Sched. M, s. 60 (1).

Same

(3) The measures for preventing and dealing with sexual abuse of patients must include,

(a) educational requirements for members;

(b) guidelines for the conduct of members with their patients;

(c) training for the College’s staff; and

(d) the provision of information to the public. 1991, c. 18, Sched. 2, s. 84 (3); 1993, c. 37, s. 22 (2); 2007, c. 10, Sched. M, s. 60 (2).

Other functions

(3.1) The patient relations program shall perform any other functions that are prescribed in regulations made under clause 43 (1) (x) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 25.

Report on program

(4) The Council shall give the Health Professions Regulatory Advisory Council a written report describing the patient relation program and, when changes are made to the program, a written report describing the changes. 1991, c. 18, Sched. 2, s. 84 (4).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 22 (1, 2) - 31/12/1993

2007, c. 10, Sched. M, s. 60 (1, 2) - 04/06/2009

2017, c. 11, Sched. 5, s. 25 - 30/05/2017

Advice to Council

85 The Patient Relations Committee shall advise the Council with respect to the patient relations program. 1991, c. 18, Sched. 2, s. 85.

REPORTING OF HEALTH PROFESSIONALS

Reporting by members

85.1 (1) A member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient.

If name not known

(2) A member is not required to file a report if the member does not know the name of the member who would be the subject of the report.

If information from a patient

(3) If a member is required to file a report because of reasonable grounds obtained from one of the member's patients, the member shall use his or her best efforts to advise the patient of the requirement to file the report before doing so. 1993, c. 37, s. 23.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 23 - 31/12/1993

Reporting by facilities

85.2 (1) A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds to believe that a member who practises at the facility is incompetent, incapacitated, or has sexually abused a patient. 1993, c. 37, s. 23; 2007, c. 10, Sched. M, s. 61.

When non-individuals have reasonable grounds

(2) For the purposes of subsection (1), a person who operates a facility but who is not an individual shall be deemed to have reasonable grounds if the individual who is responsible for the operation of the facility has reasonable grounds. 1993, c. 37, s. 23.

If name not known

(3) A person who operates a facility is not required to file a report if the person does not know the name of the member who would be the subject of the report. 1993, c. 37, s. 23.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 23 - 31/12/1993

2007, c. 10, Sched. M, s. 61 - 04/06/2009

Requirements of required reports

85.3 (1) A report required under section 85.1 or 85.2 must be filed in writing with the Registrar of the College of the member who is the subject of the report. 1993, c. 37, s. 23.

Timing of report

(2) The report must be filed within 30 days after the obligation to report arises unless the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, or that the incompetence or the incapacity of the member is likely to expose a patient to harm or injury and there is urgent need for intervention, in which case the report must be filed forthwith. 2007, c. 10, Sched. M, s. 62 (1).

Contents of report

(3) The report must contain,

(a) the name of the person filing the report;

(b) the name of the member who is the subject of the report;

(c) an explanation of the alleged sexual abuse, incompetence or incapacity;

(d) if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4). 1993, c. 37, s. 23; 2007, c. 10, Sched. M, s. 62 (2).

Patients not named without consent

(4) The name of a patient who may have been sexually abused must not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name. 1993, c. 37, s. 23.

If reporter providing psychotherapy

(5) If a member who is required to file a report under section 85.1 is providing psychotherapy to the member who would be the subject of the report, the report must also contain the opinion of the member filing the report, if he or she is able to form one, as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future. 1993, c. 37, s. 23.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 23 - 31/12/1993

2007, c. 10, Sched. M, s. 62 (1, 2) - 04/06/2009

Additional reports, psychotherapy

85.4 (1) A member who files a report in respect of which subsection 85.3 (5) applies, shall file an additional report to the same College if the member ceases to provide psychotherapy to the member who was the subject of the first report.

Timing of additional report

(2) The additional report must be filed forthwith. 1993, c. 37, s. 23.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 23 - 31/12/1993

Reporting by employers, etc.

85.5 (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a member or who dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Registrar within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons. 1993, c. 37, s. 23; 2000, c. 42, Sched., s. 36.

Same

(2) Where a member resigns, or voluntarily relinquishes or restricts his or her privileges or practice, and the circumstances set out in paragraph 1 or 2 apply, a person referred to in subsection (3) shall act in accordance with those paragraphs:

1. Where a person referred to in subsection (3) has reasonable grounds to believe that the resignation, relinquishment or restriction, as the case may be, is related to the member's professional misconduct, incompetence or incapacity, the person shall file with the Registrar within 30 days after the resignation, relinquishment or restriction a written report setting out the grounds upon which the person's belief is based.
2. Where the resignation, relinquishment or restriction, as the case may be, takes place during the course of, or as a result of, an investigation conducted by or on behalf of a person referred to in subsection (3) into allegations related to professional misconduct, incompetence or incapacity on the part of the member, the person referred to in subsection (3) shall file with the Registrar within 30 days after the resignation, relinquishment or restriction a written report setting out the nature of the allegations being investigated. 2014, c. 14, Sched. 2, s. 12.

Application

(3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services. 1993, c. 37, s. 23.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 23 - 31/12/1993

2000, c. 42, Sched., s. 36 - 01/11/2001

2014, c. 14, Sched. 2, s. 12 - 01/08/2016

Immunity for reports

85.6 No action or other proceeding shall be instituted against a person for filing a report in good faith under section 85.1, 85.2, 85.4 or 85.5. 1993, c. 37, s. 23.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 23 - 31/12/1993

Reporting by members re: offences

85.6.1 (1) A member shall file a report in writing with the Registrar if the member has been found guilty of an offence. 2007, c. 10, Sched. M, s. 63; 2009, c. 26, s. 24 (15).

Timing of report

(2) The report must be filed as soon as reasonably practicable after the member receives notice of the finding of guilt. 2007, c. 10, Sched. M, s. 63.

Contents of report

(3) The report must contain,

(a) the name of the member filing the report;

(b) the nature of, and a description of the offence;

(c) the date the member was found guilty of the offence;

(d) the name and location of the court that found the member guilty of the offence; and

(e) the status of any appeal initiated respecting the finding of guilt. 2007, c. 10, Sched. M, s. 63.

Publication ban

(4) The report shall not contain any information that violates a publication ban. 2007, c. 10, Sched. M, s. 63.

Same

(5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban. 2007, c. 10, Sched. M, s. 63.

Additional reports

(6) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding of guilt as the result of an appeal. 2007, c. 10, Sched. M, s. 63.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 63 - 04/06/2009

2009, c. 26, s. 24 (15) - 15/12/2009

Reporting by members re: professional negligence and malpractice

85.6.2 (1) A member shall file a report in writing with the Registrar if there has been a finding of professional negligence or malpractice made against the member. 2007, c. 10, Sched. M, s. 63; 2009, c. 26, s. 24 (16).

Timing of report

(2) The report must be filed as soon as reasonably practicable after the member receives notice of the finding made against the member. 2007, c. 10, Sched. M, s. 63.

Contents of report

(3) The report must contain,

(a) the name of the member filing the report;

(b) the nature of, and a description of the finding;

(c) the date that the finding was made against the member;

(d) the name and location of the court that made the finding against the member; and

(e) the status of any appeal initiated respecting the finding made against the member. 2007, c. 10, Sched. M, s. 63.

Publication ban

(4) The report shall not contain any information that violates a publication ban. 2007, c. 10, Sched. M, s. 63.

Same

(5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban. 2007, c. 10, Sched. M, s. 63.

Additional reports

(6) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding made against the member as the result of an appeal. 2007, c. 10, Sched. M, s. 63.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 63 - 04/06/2009

2009, c. 26, s. 24 (16) - 15/12/2009

Reporting by members re: other professional memberships and findings

85.6.3 (1) A member shall advise the Registrar in writing if the member is a member of another body that governs a profession inside or outside of Ontario. 2017, c. 11, Sched. 5, s. 26.

Findings of misconduct or incompetence

(2) A member shall file a report in writing with the Registrar if there has been a finding of professional misconduct or incompetence made against the member by another body that governs a profession inside or outside of Ontario. 2017, c. 11, Sched. 5, s. 26.

Timing of report

(3) The report must be filed as soon as reasonably practicable after the member receives notice of the finding made against the member. 2017, c. 11, Sched. 5, s. 26.

Contents of report

(4) The report must contain,

(a) the name of the member filing the report;

(b) the nature of, and a description of, the finding;

(c) the date that the finding was made against the member;

(d) the name and location of the body that made the finding against the member; and

(e) the status of any appeal initiated respecting the finding made against the member. 2017, c. 11, Sched. 5, s. 26.

Publication ban

(5) The report shall not contain any information that violates a publication ban. 2017, c. 11, Sched. 5, s. 26.

Same

(6) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban. 2017, c. 11, Sched. 5, s. 26.

Additional reports

(7) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding made against the member as the result of an appeal. 2017, c. 11, Sched. 5, s. 26.

Section Amendments with date in force (d/m/y)

2017, c. 11, Sched. 5, s. 26 - 01/05/2018

Reporting by members re: charges and bail conditions, etc.

85.6.4 (1) A member shall file a report in writing with the Registrar if the member has been charged with an offence, and the report shall include information about every bail condition or other restriction imposed on, or agreed to, by the member in connection with the charge. 2017, c. 11, Sched. 5, s. 27.

Timing of report

(2) The report must be filed as soon as reasonably practicable after the member receives notice of the charge, bail condition or restriction. 2017, c. 11, Sched. 5, s. 27.

Contents of report

(3) The report must contain,

(a) the name of the member filing the report;

(b) the nature of, and a description of, the charge;

(c) the date the charge was laid against the member;

(d) the name and location of the court in which the charge was laid or in which the bail condition or restriction was imposed on or agreed to by the member;

(e) every bail condition imposed on the member as a result of the charge;

(f) any other restriction imposed on or agreed to by the member relating to the charge; and

(g) the status of any proceedings with respect to the charge. 2017, c. 11, Sched. 5, s. 27.

Publication ban

(4) The report shall not contain any information that violates a publication ban. 2017, c. 11, Sched. 5, s. 27.

Same

(5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban. 2017, c. 11, Sched. 5, s. 27.

Additional reports

(6) A member who files a report under subsection (1) shall file an additional report if there is a change in the status of the charge or bail conditions. 2017, c. 11, Sched. 5, s. 27.

Section Amendments with date in force (d/m/y)

2017, c. 11, Sched. 5, s. 27 - 01/05/2018

FUNDING FOR THERAPY AND COUNSELLING

Funding provided by College

85.7 (1) There shall be a program, established by the College, to provide funding for the following purposes in connection with allegations of sexual abuse by members:

1. Therapy and counselling for persons alleging sexual abuse by a member.
2. Any other purposes prescribed in regulations made under clause 43 (1) (y) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 28 (1).

Funding governed by regulations

(2) The funding shall be provided in accordance with the regulations made under the *Regulated Health Professions Act, 1991*. 1993, c. 37, s. 23.

Administration

(3) The Patient Relations Committee shall administer the program. 1993, c. 37, s. 23.

Eligibility

(4) A person is eligible for funding if,

(a) it is alleged, in a complaint or report, that the person was sexually abused by a member while the person was a patient of the member; or

(b) the alternative requirements prescribed in the regulations made by the Council are satisfied. 2017, c. 11, Sched. 5, s. 28 (2).

Timing

(5) Where a request is made for funding pursuant to subsection (1), a determination of the person's eligibility for such funding in accordance with subsection (4) shall be made within a reasonable period of time of the request having been received. 2017, c. 11, Sched. 5, s. 28 (2).

Not a finding

(5.1) The determination of a person's eligibility for funding in accordance with subsection (4) does not constitute a finding against the member and shall not be considered by any other committee of the College dealing with the member. 2017, c. 11, Sched. 5, s. 28 (2).

Cessation of eligibility

(5.2) Despite subsection (4), a person's eligibility to receive funding pursuant to subsection (1) ceases upon the occurrence of any of the prescribed circumstances. 2017, c. 11, Sched. 5, s. 28 (2).

No assessment

(6) A person is not required to undergo a psychological or other assessment before receiving funding. 1993, c. 37, s. 23.

Choice of therapist or counsellor

(7) A person who is eligible for funding is entitled to choose any therapist or counsellor, subject to the following restrictions:

1. The therapist or counsellor must not be a person to whom the eligible person has any family relationship.
2. The therapist or counsellor must not be a person who, to the College's knowledge, has at any time or in any jurisdiction been found guilty of professional misconduct of a sexual nature or been found civilly or criminally liable for an act of a similar nature.
3. If the therapist or counsellor is not a member of a regulated health profession, the College may require the person to sign a document indicating that he or she understands that the therapist or counsellor is not subject to professional discipline. 1993, c. 37, s. 23.

Payment

(8) Funding shall be paid only to the therapist or counsellor chosen by the person or to other persons or classes of persons prescribed in any regulation made under clause 43 (1) (y) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 28 (3).

Use of funding

(9) Funding shall be used only to pay for therapy or counselling and for any other purposes prescribed in any regulation made under clause 43 (1) (y) of the *Regulated Health Professions Act, 1991* and shall not be applied directly or indirectly for any other purpose. 2017, c. 11, Sched. 5, s. 28 (3).

Same

(10) Funding may be used to pay for therapy or counselling that was provided at any time after the alleged sexual abuse took place. 2017, c. 11, Sched. 5, s. 28 (3).

Other coverage

(11) The funding that is provided to a person for therapy and counselling shall be reduced by the amount that the Ontario Health Insurance Plan or a private insurer is required to pay for therapy or counselling for the person during the period of time during which funding may be provided for the person under the program. 2017, c. 11, Sched. 5, s. 28 (3).

Right of recovery

(12) The College is entitled to recover from the member, in a proceeding brought in a court of competent jurisdiction, money paid in accordance with this section for an eligible person referred to in subsection (4). 2017, c. 11, Sched. 5, s. 28 (3).

Person not required to testify

(13) The eligible person shall not be required to appear or testify in the proceeding. 1993, c. 37, s. 23.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 23 - 31/12/1993

2007, c. 10, Sched. M, s. 64 - 04/06/2009

2017, c. 11, Sched. 5, s. 28 (1-3) - 01/05/2018

HEALTH PROFESSION CORPORATIONS

Professional corporations

85.8 (1) Subject to the regulations made under subsection 43 (1) of the *Regulated Health Professions Act, 1991* and the by-laws, one or more members of the same health profession

may establish a health profession corporation for the purposes of practising their health profession. 2005, c. 28, Sched. B, s. 2 (1).

Same

(2) The provisions of the *Business Corporations Act*, including the regulations made under that Act, that apply with respect to professional corporations apply with respect to a health profession corporation established under subsection (1). 2005, c. 28, Sched. B, s. 2 (1).

Section Amendments with date in force (d/m/y)

2000, c. 42, Sched., s. 37 - 01/11/2001

2001, c. 8, s. 219 - 01/11/2001

2005, c. 28, Sched. B, s. 2 (1) - 01/01/2006

Notice of change of shareholder

85.9 A health profession corporation shall notify the Registrar within the time and in the form and manner determined under the by-laws of a change in the shareholders of the corporation who are members of the College. 2000, c. 42, Sched., s. 37; 2007, c. 10, Sched. M, s. 69.

Section Amendments with date in force (d/m/y)

2000, c. 42, Sched., s. 37 - 01/11/2001

2007, c. 10, Sched. M, s. 69 - 04/06/2009

Application of Act, etc.

85.10 The following things apply to a member who practises a health profession through a health profession corporation:

1. The *Regulated Health Professions Act, 1991* and the regulations made under that Act.
2. The health profession Act governing the member's health profession and the regulations and by-laws made under that Act. 2001, c. 8, s. 220; 2007, c. 10, Sched. M, s. 65.

Section Amendments with date in force (d/m/y)

2001, c. 8, s. 220 - 01/11/2001

2007, c. 10, Sched. M, s. 65 - 04/06/2009

Professional, fiduciary and ethical obligations to patients

85.11 (1) The professional, fiduciary and ethical obligations of a member to a person on whose behalf the member is practising a health profession,

(a) are not diminished by the fact that the member is practising through a health profession corporation; and

(b) apply equally to the corporation and to its directors, officers, shareholders, agents and employees. 2000, c. 42, Sched., s. 37; 2001, c. 8, s. 221 (1).

Investigation

(2) Subsections (3) and (4) apply if an action or the conduct of a member practising on behalf of a health profession corporation is the subject of one of the following:

1. A complaint.
2. A mandatory report.
3. A specified allegation of professional misconduct or incompetence.
4. An investigation, review or hearing by the Board.
5. An investigation, inspection or assessment by an investigator or assessor appointed under the Code.
6. An inquiry by a panel of the Inquiries, Complaints and Reports Committee.

7. A referral to the Discipline Committee or the Fitness to Practise Committee.
8. A hearing by a committee of the college. 2001, c. 8, s. 221 (2); 2007, c. 10, Sched. M, s. 66.

Same

(3) In the circumstances described in subsection (2), any power that the College may exercise in respect of the member may be exercised in respect of the health profession corporation. 2001, c. 8, s. 221 (2).

Liability

(4) In the circumstances described in subsection (2), the health profession corporation is jointly and severally liable with the member for all fines, costs and expenses that the member is ordered to pay. 2001, c. 8, s. 221 (2).

Section Amendments with date in force (d/m/y)

2000, c. 42, Sched., s. 37 - 01/11/2001

2001, c. 8, s. 221 (1, 2) - 01/11/2001

2007, c. 10, Sched. M, s. 66 - 04/06/2009

Conflict in duties

85.12 If there is a conflict between a member's duty to a patient, the college or the public and the member's duty to a health profession corporation as a director or officer of the corporation, the duty to the patient, the college or the public prevails. 2001, c. 8, s. 222.

Section Amendments with date in force (d/m/y)

2001, c. 8, s. 222 - 01/11/2001

Restrictions apply to corporation's certificate

85.13 A term, condition or limitation imposed on the certificate of registration of a member practising a health profession through a health profession corporation applies to the certificate of authorization of the corporation in relation to the practice of the health profession through the member. 2000, c. 42, Sched., s. 37.

Section Amendments with date in force (d/m/y)

2000, c. 42, Sched., s. 37 - 01/11/2001

Prohibition, professional misconduct

85.14 (1) In the course of practising a health profession, a health profession corporation shall not do, or fail to do, something that would constitute professional misconduct if a member of the health profession did, or failed to do, it. 2001, c. 8, s. 223.

Prohibition, contraventions

(2) A health profession corporation shall not contravene any provision of,

(a) the *Regulated Health Professions Act, 1991* and the regulations made under that Act; or

(b) the health profession Act governing the member's health profession and the regulations and by-laws made under that Act. 2001, c. 8, s. 223; 2007, c. 10, Sched. M, s. 67.

Prohibition, corporate matters

(3) A health profession corporation shall not practise a health profession when it does not satisfy the requirements for a professional corporation under subsection 3.2 (2) of the *Business Corporations Act* or a requirement established under subsection 3.2 (6) of that Act. 2005, c. 28, Sched. B, s. 2 (2).

Section Amendments with date in force (d/m/y)

2001, c. 8, s. 223 - 01/11/2001

2005, c. 28, Sched. B, s. 2 (2) - 01/01/2006

2007, c. 10, Sched. M, s. 67 - 04/06/2009

MISCELLANEOUS

Right to use French

86 (1) A person has the right to use French in all dealings with the College. 1991, c. 18, Sched. 2, s. 86 (1).

Language preferences

(1.1) The College shall identify and record the language preference of each College member and identify the language preference of each member of the public who has dealings with the College. 2007, c. 10, Sched. M, s. 68.

Council to ensure right

(2) The Council shall take all reasonable measures and make all reasonable plans to ensure that persons may use French in all dealings with the College. 1991, c. 18, Sched. 2, s. 86 (2).

Definition

(3) In this section,

"dealings" means any service or procedure available to the public or to members and includes giving or receiving communications, information or notices, making applications, taking examinations or tests and participating in programs or in hearings or reviews. 1991, c. 18, Sched. 2, s. 86 (3).

Limitation

(4) A person's right under subsection (1) is subject to the limits that are reasonable in the circumstances. 1991, c. 18, Sched. 2, s. 86 (4).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 68 - 04/06/2009

Court orders

87 The College may apply to the Superior Court of Justice for an order directing a person to comply with a provision of the health profession Act, this Code, the *Regulated Health Professions Act, 1991*, the regulations under those Acts or the by-laws made under clause 94 (1) (l.2), (l.3) (s), (t), (t.1), (t.2), (v), (w) or (y). 1991, c. 18, Sched. 2, s. 87; 1998, c. 18, Sched. G, s. 20; 2000, c. 42, Sched., s. 38; 2001, c. 8, s. 224; 2006, c. 19, Sched. C, s. 1 (1).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 20 - 1/02/1999

2000, c. 42, Sched., s. 38 - 01/11/2001

2001, c. 8, s. 224 - 01/11/2001

2006, c. 19, Sched. C, s. 1 (1) - 22/06/2006

Evidence of Registrar

88 A statement purporting to be certified by the Registrar under the seal of the College as a statement of information from the records kept by the Registrar in the course of his or her duties is admissible in court as proof, in the absence of evidence to the contrary, of the information in it without proof of the Registrar's appointment or signature or of the seal of the College. 1991, c. 18, Sched. 2, s. 88.

89 REPEALED: 2002, c. 24, Sched. B, s. 25.

Section Amendments with date in force (d/m/y)

2001, c. 8, s. 225 - 01/11/2001

2002, c. 24, Sched. B, s. 25 - 01/01/2004

90 REPEALED: 1993, c. 37, s. 24.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 24 - 31/12/1993

91 REPEALED: 2007, c. 10, Sched. M, s. 70.

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. M, s. 70 - 04/06/2007

Making false representations to obtain certificates

92 (1) Every person who makes a representation, knowing it to be false,

(a) for the purpose of having a certificate of registration issued is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or

(b) for the purpose of having a certificate of authorization issued is guilty of an offence and on conviction is liable to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 71.

Assisting the making of false representation

(2) Every person who knowingly assists a person in committing an offence under subsection (1) is guilty of an offence and on conviction is liable,

(a) in the case of an individual, to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or

(b) in the case of a corporation, to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 71.

Section Amendments with date in force (d/m/y)

2000, c. 42, Sched., s. 39 - 01/11/2001

2007, c. 10, Sched. M, s. 71 - 04/06/2007

Protection for reporters from reprisals

92.1 No person shall do anything, or refrain from doing anything, relating to another person's employment or to a contract providing for the provision of services by that other person, in retaliation for that other person filing a report or making a complaint as long as the report was filed, or the complaint was made, in good faith. 1993, c. 37, s. 25.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 25 - 31/12/1993

Offences

93 (1) Every person who contravenes an order made under subsection 7 (3) or section 45 or 47, or who contravenes subsection 76 (3), 82 (2) or (3), 85.2 (1), 85.5 (1) or (2) or 85.14 (2) or section 92.1 is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 72; 2009, c. 26, s. 24 (17).

Same

(2) Every person who contravenes subsection 85.1 (1) or 85.4 (1) is guilty of an offence and on conviction is liable to a fine of not more than $50,000. 2017, c. 11, Sched. 5, s. 29.

Sexual abuse reporting by facilities

(3) Despite subsection (1), every person who contravenes subsection 85.2 (1) in respect of a matter concerning the sexual abuse of a patient is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than $50,000; or

(b) in the case of a corporation to a fine of not more than $200,000. 2017, c. 11, Sched. 5, s. 29.

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 26 (1, 2) - 31/12/1993

2007, c. 10, Sched. M, s. 72 - 04/06/2007

2009, c. 26, s. 24 (17) - 15/12/2009

2017, c. 11, Sched. 5, s. 29 - 30/05/2017

Forms

93.1 The College may require that forms approved by the College be used for any purpose under the Act. 1998, c. 18, Sched. G, s. 21.

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 21 - 01/02/1999

By-laws

94 (1) The Council may make by-laws relating to the administrative and internal affairs of the College and, without limiting the generality of the foregoing, the Council may make by-laws,

(a) adopting a seal for the College;

(b) providing for the execution of documents by the College;

(c) respecting banking and finance;

(d) fixing the financial year of the College and providing for the audit of the accounts and transactions of the College;

(d.1) respecting the election of Council members, including the requirements for members to be able to vote, electoral districts and election recounts;

(d.2) respecting the qualification and terms of office of Council members who are elected;

(d.3) prescribing conditions disqualifying elected members from sitting on the Council and governing the removal of disqualified Council members;

(e) providing procedures for the election of the President and Vice-President of the College, the selection of the chairs of the committees, the filling of a vacancy in those offices, and setting out the duties and powers of the President, Vice-President and the chairs;

(f) respecting the calling, holding and conducting of the Council meetings and respecting the duties of the Council's members;

(g) respecting the calling, holding and conducting of meetings of the members;

(g.1) providing that a meeting of the Council or of members or a meeting of a committee or of a panel that is held for any purpose other than for the conducting of a hearing may be held in any manner that allows all the persons participating to communicate with each other simultaneously and instantaneously;

(g.2) prescribing what constitutes a conflict of interest for members of the Council or a committee and regulating or prohibiting the carrying out of the duties of those members in cases in which there is a conflict of interest;

(h) providing for the remuneration of the members of the Council and committees other than persons appointed by the Lieutenant Governor in Council and for the payment of the expenses of the Council and committees in the conduct of their business;

(h.1) respecting the filling of vacancies on the Council or on committees;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 94 (1) (h.1) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 30 (1))

(h.1) subject to the regulations made under clauses 43 (1) (p) to (s) of the *Regulated Health Professions Act, 1991*,

(i) respecting the filling of vacancies on the Council or on committees,

(ii) providing for the composition of committees,

(iii) respecting the qualification, selection, appointment and terms of office of members of committees required by subsection 10 (1) who are not members of the Council,

(iv) prescribing conditions that disqualify committee members from sitting on committees required under subsection 10 (1) and governing the removal of disqualified committee members;

(h.2) providing for the composition of committees;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 94 (1) (h.2) of Schedule 2 to the Act is repealed. (See: 2017, c. 11, Sched. 5, s. 30 (1))

(h.3) respecting the qualification, selection, appointment and terms of office of members of committees required by subsection 10 (1) who are not members of the Council;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 94 (1) (h.3) of Schedule 2 to the Act is repealed. (See: 2017, c. 11, Sched. 5, s. 30 (1))

(h.4) prescribing conditions disqualifying committee members from sitting on committees required under subsection 10 (1) and governing the removal of disqualified committee members;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 94 (1) (h.4) of Schedule 2 to the Act is repealed. (See: 2017, c. 11, Sched. 5, s. 30 (1))

(i) providing for the appointment, powers and duties of committees other than the committees required by subsection 10 (1);

(j) delegating to the Executive Committee powers and duties of the Council, other than the power to make, amend or revoke regulations and by-laws;

(k) providing for a code of ethics for the members;

(l) providing for the appointment of inspectors for the purposes of regulations made under clause 95 (1) (h);

(l.1) respecting the maintenance of the register kept by the Registrar and providing for the issuing of certificates when information contained in the register is made available to the public under section 23;

(l.2) specifying information as information to be kept in the register for the purposes of paragraph 20 of subsection 23 (2), designating information kept in the register as public for the purposes of subsection 23 (5), and designating information kept in the register as public for the purposes of subsection 23 (5) that may be withheld from the public for the purposes of subsection 23 (6);

(l.3) requiring members to give the College their home addresses and such other information as may be specified in the by-law about themselves and the places they practise the profession, the services they provide there, their participation in continuing education programs and the names, business addresses, telephone numbers and facsimile numbers of their associates, partners, employers and employees and prescribing the form and manner in which the information shall be given;

(l.4) respecting the duties and office of the Registrar;

(m) providing procedures for the making, amending and revoking of by-laws;

(n) prescribing forms and providing for their use;

(o) respecting the management of the property of the College;

(p) authorizing the College to make arrangements for the indemnity of members against professional liability and providing levies to be paid by members;

(q) respecting membership of the College in a national organization of bodies with similar functions, the payment of annual assessments and representation at meetings;

(r) authorizing the making of grants to advance scientific knowledge or the education of persons wishing to practise the profession, to maintain or improve the standards of practice of the profession or to provide public information about, and encourage interest in, the past and present role of the profession in society;

(s) requiring members to pay annual fees, fees upon application for a certificate and upon registration and fees for examinations, appeals from examinations, election recounts and continuing education programs and for anything the Registrar or a committee of the College is required or authorized to do and requiring members to pay penalties for the late payment of any fee;

(t) specifying the amount of any fee or penalty required under clause (s);

(t.1) prescribing the form and manner in which a health profession corporation shall notify the Registrar of a change in the shareholders of the corporation and the time period for doing so;

(t.2) requiring the payment of fees upon application for a certificate of authorization and for the issue or renewal of a certificate of authorization and specifying the amount of such fees;

(u) requiring persons to pay fees, set by the Registrar or by by-law, for anything the Registrar is required or authorized to do;

(v) requiring members to pay specified amounts to pay for the program required under section 85.7, including amounts that are different for different members or classes of members and including amounts,

(i) that are specified in the by-law,

(ii) that are calculated according to a method set out in the by-law, or

(iii) that are determined by a person specified in the by-law;

(w) requiring members to participate in an arrangement set up by the College in which members pay a person such amounts as may be determined by the person for the members or for classes of members and the person pays amounts to the College to pay for the program required under section 85.7;

(x) authorizing the Patient Relations Committee to require therapists and counsellors who are providing therapy or counselling that is funded through the program required under section 85.7 and persons who are receiving such therapy or counselling, to provide a written statement, signed in each case by the therapist or counsellor and by the person, containing details of the therapist's or counsellor's training and experience, and confirming that therapy or counselling is being provided and that the funds received are being devoted only to that purpose;

(y) requiring members to have professional liability insurance that satisfies the requirements specified in the by-laws or to belong to a specified association that provides protection against professional liability and requiring members to give proof of the insurance or membership to the Registrar in the manner set out in the by-laws;

(z) respecting the designation of life or honourary members of the College and prescribing their rights and privileges;

(z.1) exempting any member or class of member from a by-law made under this section;

(z.2) specifying or setting out anything that is required to be specified or set out under this subsection. 1991, c. 18, Sched. 2, s. 94 (1); 1998, c. 18, Sched. G, s. 22 (1-4); 2000, c. 42, Sched., s. 40; 2007, c. 10, Sched. M, s. 73 (1, 2); 2017, c. 11, Sched. 5, s. 30 (2).

Circulation of certain by-laws

(2) A by-law shall not be made under clause (1) (l.2), (l.3), (s), (t), (v), (w) or (y) unless the proposed by-law is circulated to every member at least 60 days before it is approved by the Council. 1998, c. 18, Sched. G, s. 22 (5).

Exception

(2.1) Despite subsection (2), the Council may, with the approval of the Minister, exempt a by-law from the requirement that it be circulated or abridge the 60-day period referred to in subsection (2) to such lesser period as the Minister may determine. 1998, c. 18, Sched. G, s. 22 (5).

Copies of by-laws, etc.

(3) A copy of the by-laws and standards of practice made by the Council, and any documents that are referred to in the by-laws and regulations made by the Council shall be given to the Minister and to each member and shall be made available to the public during normal business hours in the office of the College. 2007, c. 10, Sched. M, s. 73 (3).

Public copies

(3.1) Any person is entitled to a copy of any by-law, standard of practice or other document mentioned in subsection (3) on the payment of a reasonable fee, if required, to the Registrar. 2007, c. 10, Sched. M, s. 73 (3).

Unanimous by-laws, etc.

(4) A by-law or resolution signed by all the members of the Council is as valid and effective as if passed at a meeting of the Council called, constituted and held for the purpose. 1991, c. 18, Sched. 2, s. 94 (4).

Application

(5) Subsections (3) and (4) apply to by-laws made under this section or under a health profession Act. 1998, c. 18, Sched. G, s. 22 (6).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 22 (1-6) - 01/02/1999

2000, c. 42, Sched., s. 40 - 01/11/2001

2007, c. 10, Sched. M, s. 73 (1-3) - 04/06/2009

2017, c. 11, Sched. 5, s. 30 (1) - not in force; 2017, c. 11, Sched. 5, s. 30 (2) - 30/05/2017

Regulations

95 (1) Subject to the approval of the Lieutenant Governor in Council and with prior review of the Minister, the Council may make regulations,

(0.a) providing that the spousal exception in subsection 1 (5) applies in respect of the College;

(a) prescribing classes of certificates of registration and imposing terms, conditions and limitations on the certificates of registration of a class;

(b) respecting applications for certificates of registration or classes of them and the issuing, suspension, revocation and expiration of the certificates or classes of them;

(c) prescribing standards and qualifications for the issue of certificates of registration;

(d) prescribing certain registration requirements as non-exemptible requirements for the purposes of subsection 18 (3) and 22 (8);

(e) defining specialties in the profession, providing for certificates relating to those specialties, the qualifications for and suspension and revocation of those certificates and governing the use of prescribed terms, titles or designations by members indicating a specialization in the profession;

(f) requiring, for purposes associated with the registration of members, the successful completion of examinations as set and approved, from time to time, by the College, other persons or associations of persons and providing for an appeal of the results of the examinations;

(g) governing or prohibiting the delegation by or to members of controlled acts set out in subsection 27 (2) of the *Regulated Health Professions Act, 1991*;

(h) requiring and providing for the inspection and examination of premises used in connection with the practice of the profession and of equipment, books, accounts, reports and records of members relating to their practices;

(h.1) providing for the direct observation of a member in his or her practice, including the direct observation by inspectors of procedures, during the course of an inspection or examination provided for under clause (h);

(i) prescribing what constitutes a conflict of interest in the practice of the profession and regulating or prohibiting the practice of the profession in cases in which there is a conflict of interest;

(j) defining professional misconduct for the purposes of clause 51 (1) (c);

(k) designating acts of professional misconduct that must be reported;

(l) respecting the promotion or advertising of the practice of the profession;

(m) respecting the reporting and publication of decisions of panels;

(n) prescribing the standards of practice of the profession and prohibiting members from acting beyond the scope of practice of the profession in the course of practising the profession;

(o) requiring members to keep prescribed records in respect of their practice;

(p) regulating or prohibiting the use of terms, titles and designations by members in respect of their practices;

(q) prescribing alternative requirements for eligibility for funding under clause 85.7 (4) (b);

(q.1) prescribing the circumstances in respect of which a person's eligibility for funding ceases for the purposes of subsection 85.7 (5.2);

(r) prescribing a quality assurance program;

(r.1) specifying information for the purposes of clause (g) of the definition of "quality assurance information" in subsection 83.1 (1);

(s) respecting the giving of notice of meetings and hearings that are to be open to the public;

(t) providing for the exemption of any member from the regulations made by the Council;

(u) prescribing anything that is referred to in the health profession Act or this Code as being prescribed. 1998, c. 18, Sched. G, s. 23 (1); 2004, c. 3, Sched. B, s. 11 (3); 2007, c. 10, Sched. M, s. 74 (1); 2009, c. 6, s. 2; 2013, c. 9, s. 1 (2); 2017, c. 11, Sched. 5, s. 31.

Note: The following apply with respect to regulations made under paragraphs 1 to 7, 14, 22, 23, 27 to 31, 31.2 to 32, 34, 35 and 38 of subsection 95 (1) that are in force immediately before the Statutes of Ontario, 1998, chapter 18, Schedule G, subsection 23 (1) comes into force:

Despite the coming into force of the Statutes of Ontario, 1998, chapter 18, Schedule G, subsection 23 (1) (repealing the authority under which the regulations are made), the regulations shall be deemed to continue in force until they are revoked by the authority that made them.

A reference to by-laws in any Act listed in Schedule 1 shall be deemed to include a reference to regulations which are deemed to continue in force. See: 1998, c. 18, Sched. G, ss. 23 (2-4), 74.

Standards of practice

(1.1) A regulation under clause (1) (n) may adopt by reference, in whole or in part and with such changes as are considered necessary, any code, standard or guideline relating to standards of practice of the profession and require compliance with the code, standard or guideline as adopted. 1998, c. 18, Sched. G, s. 23 (1).

Rolling incorporation

(1.2) If a regulation under subsection (1.1) so provides, a scientific, administrative or technical document adopted by reference shall be a reference to it, as amended from time to time, and

whether the amendment was made before or after the regulation was made. 2007, c. 10, Sched. M, s. 74 (2).

Third party external document

(1.2.1) A document adopted under subsection (1.2) must be a document created by a recognized body and must not be a document created by the College. 2007, c. 10, Sched. M, s. 74 (2).

Exception

(1.2.2) Despite subsection (1.2.1), the incorporation by reference of a document created by the College that was made before the coming into force of that subsection remains valid until it is revoked. 2007, c. 10, Sched. M, s. 74 (2).

Copies available for inspection

(1.3) A copy of every code, standard or guideline adopted by reference under subsection (1.1) shall be available for public inspection during normal business hours in the office of the College and shall be posted on the College's website or be available through a hyperlink at the College's website. 2007, c. 10, Sched. M, s. 74 (2).

Circulation

(1.4) A regulation shall not be made under subsection (1) unless the proposed regulation is circulated to every member at least 60 days before it is approved by the Council. 1998, c. 18, Sched. G, s. 23 (1).

Same

(1.5) Subsection (1.4) does not apply to a regulation if the Minister required that the Council make the regulation under clause 5 (1) (c) of the *Regulated Health Professions Act, 1991*. 1998, c. 18, Sched. G, s. 23 (1).

Exception

(1.6) Despite subsection (1.4), the Council may, with the approval of the Minister, exempt a regulation from the requirement that it be circulated or abridge the 60-day period referred to in subsection (1.4) to such lesser period as the Minister may determine. 1998, c. 18, Sched. G, s. 23 (1).

Adopted documents

(1.7) Subsections (1.4) and (1.6) apply with necessary modifications to an amendment to a scientific, administrative or technical document adopted by reference under subsection (1.1). 2007, c. 10, Sched. M, s. 74 (3).

Quality assurance program – continuing education

(2) Regulations made under clause (1) (r) may require members to participate in continuing education programs. 1991, c. 18, Sched. 2, s. 95 (2); 2000, c. 26, Sched. H, s. 3 (2).

(2.1), (2.2) REPEALED: 2007, c. 10, Sched. M, s. 74 (4).

Scope of regulations

(3) A regulation may be general or particular in its application. 1991, c. 18, Sched. 2, s. 95 (3).

Section Amendments with date in force (d/m/y)

1993, c. 37, s. 27 (2) - 31/12/1993; 1998, c. 18, Sched. G, s. 23 (1) - 01/02/1999

2000, c. 26, Sched. H, s. 3 (2, 3) - 06/12/2000

2004, c. 3, Sched. B, s. 11 (3) - 20/05/2004

2006, c. 19, Sched. L, s. 10 (2) - 22/06/2006

2007, c. 10, Sched. M, s. 74 (1-4) - 04/06/2009

2009, c. 6, s. 2 - 23/04/2009

2013, c. 9, s. 1 (2) - 06/11/2013
2017, c. 11, Sched. 5, s. 31 - 01/05/2018

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Optometry Act

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Optometry Act

Each health profession has its own profession-specific Act. The *Optometry Act* includes the scope of practice of optometry and the controlled acts authorized to optometrists. It also includes details about record keeping, registration requirements, the College's quality assurance program, and what constitutes professional misconduct for the profession.

Scope of Practice, Authorized Acts and Prescribed Diseases

The Scope of Practice defines the parameters of the practice of optometry in Ontario. Paragraph 3 of the *Optometry Act* provides a definition of the scope of practice for the profession. Paragraph 4 identifies the controlled acts authorized to optometry. Both the scope of practice and the authorized acts provisions refer to prescribed diseases. Part VIII of the General Regulation of the *Optometry Act* defines prescribed diseases. In order to truly understand the scope of practice and the authorized acts, it's important to look at them together with the definition of prescribed diseases.

The *scope of practice*, with the ***prescribed diseases definition*** inserted, is as follows:

> *The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of:*
>
> *a. disorders of refraction;*
>
> *b. sensory and oculomotor disorder and dysfunctions of the eye and vision system; and*
>
> **c.** *prescribed diseases.* ***In relation to diagnosis and prevention, these are diseases of the eye and vision system that can be determined by the findings from an oculo-visual assessment. In relation to treatment, these are diseases of the eye and vision system that can be treated by other than the application of surgery.***

The *authorized acts,* with the ***prescribed diseases definition*** inserted, are as follows:

> *In the course of engaging in the practice of optometry, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:*
>
> ***1.*** *Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or any* ***disease limited to and manifested in the eye and vision system that was determined by the findings from an oculo-visual assessment.***
>
> *2. Applying a prescribed form of energy.*

2.1 Prescribing drugs designated in the regulations.

3. *Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.*

Designated Drugs Regulation

The Designated Drugs Regulation designates the drugs that optometrists are authorized to prescribe. Only those optometrists, who have met the requirements established by the College to perform the controlled act of prescribing drugs, are authorized to prescribe drugs. The Regulation specifies the training requirements to prescribe drugs, expectations for prescription writing and record-keeping, as well as standards of practice for prescribing drugs for the treatment of glaucoma. A list of drugs that optometrists are authorized to prescribe is appended as Schedule 1.

Professional Misconduct Regulation

The Professional Misconduct Regulation identifies more than 39 acts of professional misconduct and covers both the clinical and administrative functions of optometric practice. It is important for members to be familiar with all of the acts of professional misconduct identified by the Regulation. The College has developed policy guidelines for some of them, including release of a prescription, discontinuing services to a patient and advertising. These policies are included in the Jurisprudence Resource Binder.

Standards of Practice

Failure to maintain the standards of practice of the profession is an act of professional misconduct identified in the Professional Misconduct Regulation. The standards of practice are articulated in the Optometric Practice Reference (OPR). This document, available on the College website, is used by members, College committees, and the public.

The Inquiries, Complaints and Reports Committee and Discipline Committee employ the College's published standards when determining if a member has met the standard of practice. The Quality Assurance Committee uses the published standards as the basis for the development and application of the record assessment tools that its assessors use when conducting practice assessments.

Use of Pharmaceuticals

Optometrists in Ontario have been authorized to use diagnostic drugs for more than 25 years. The scope of practice has recently been expanded to include treatment of ocular disease with therapeutic pharmaceutical agents (TPAs). Only those optometrists authorized by the College to do so, may prescribe drugs for the treatment of ocular disease.

There is a difference between using or applying drugs, and prescribing drugs. Drugs are used by an optometrist in his or her office in the course of providing care to a patient. Instilling a drop of proparacaine in the eye when performing tonometry is an example of using a drug. Prescribing involves issuing a prescription to the patient for a medication that is usually instilled in the eye or taken by the patient over a period of time outside of the optometrist's office.

Optometrists may recommend over-the-counter drugs but sampling a drug, i.e., using a drug in the office and giving the patient the remainder of the bottle to use at home, is considered to be dispensing. Optometrists cannot dispense drugs and this is a controlled that is act not authorized to optometry in Ontario.

All optometrists may initiate treatment in an emergency to stabilize a patient's condition until a referral for continued treatment is arranged. Examples of emergency situations can be found in 'OPR 4.4 The Use and Prescribing of Drugs in Optometric Practice in the Optometric Practice Reference (OPR).

The consequences for inappropriate use drugs by an optometrist can be significant. It can result in an adverse outcome for the patient and may result in allegations of professional misconduct for the practitioner.

Delegation and Assignment

An optometrist may authorize another individual to carry out optometric tasks. 'Assignment' refers to tasks and procedures that are not controlled acts. The word 'delegation' is used when those tasks are controlled acts authorized to optometry. Regulated health professionals are given the authority to delegate by the RHPA.

Delegation and assignment allows for more timely and effective delivery of optometric care. However, in the public interest it is important to ensure that appropriate processes are in place. The Delegation and Assignment Policy in the Optometric Practice Reference outlines these processes in detail. For example, an optometrist may only delegate a controlled act if the following conditions are met:

- he or she must be present in the office;
- the acts must be part of the optometrist's regular practice and competence;
- the patient must be informed and provide consent for the delegation to take place; and
- the delegation must be documented in the patient's health record, etc.

For both delegation and assignment, there must be appropriate initial education for the individual performing the task, and mechanisms to ensure his or her ongoing competence. Examples of tasks that are not controlled acts that could be assigned to optometric staff include non-contact tonometry, taking of a patient history, and teaching a patient to insert contact lenses.

At times, it may be in the patient's best interest for an optometrist to receive delegation from another regulated health professional of a controlled act not authorized to optometry. The Delegation and Assignment Policy outlines the criteria that must be met in order for this to take place, such as:

- the act is clearly defined;
- the regulated health professional from whom the optometrist is receiving the delegation is authorized to delegate the act and can perform the act competently;
- the optometrist is competent to perform the act safely and effectively; and
- the duration of the delegation is clearly defined, etc.

Prescriptions for Drugs

A prescription for drugs must clearly identify the prescriber, the patient and the date the drug is prescribed. In addition, it must also contain information regarding the drug, including name, dose and dose form, any directions to the pharmacist and patient and the optometrist's registration number and original signature. Clinical justification and support for any prescription issued for drugs must be recorded in the patient health record.

Optical Prescriptions

An optical prescription is based upon the diagnosis and analysis of all available clinical information obtained from an optometric examination. In addition to identifying the prescriber, patient, date, and expiry date, the optical prescription must also contain information that is used by a dispenser to fabricate the eyeglasses, contact lenses or subnormal vision device that will provide the required vision correction for the patient. When combined with further appliance-specific information, the prescription enables the patient to obtain spectacles, contact lenses or a sub-normal vision device. The Optometric Practice Reference (OPR), and three additional policies in the Jurisprudence Resource Binder, provide additional information regarding prescriptions.

A prescription for spectacles includes information required to provide the vision correction which is clinically indicated while leaving as much freedom as possible to the patient and dispenser to select additional details. If an optometric exam results in a prescription for the patient, it **must** be released to the patient. If the patient requests a prescription for contact lenses, the optometrist is only required to release the prescription if the appropriate assessment and analysis required to dispense contact lenses have been completed, and the patient has paid for the service.

Advertising

The advertising regulation is found in paragraph 22. A guideline for members advertising their practice is included in the Jurisprudence Resource Binder. Advertising should be truthful and understandable and serve the public interest. It must be informational and not persuasive. There are restrictions on advertising: superlative statements cannot be used (i.e., best eye exam in town) and testimonials are prohibited.

Practice Names

When an optometrist works in a practice with a name other than his or her own name, the College must be advised of the practice name and the names of the optometrists practising at the location. Practice Names must be compliant with the advertising regulation.

Conflicts of Interest

Engaging in the practice of the profession while in a conflict of interest is an act of professional misconduct, and conflicts of interest are described in Part II of the Professional Misconduct Regulation. Conflict of interest regulations ensure that the regulated health professional acts in the patient's best interests above their own self-interest. The purpose of conflict of interest regulations is to earn and maintain the public's trust. The Conflict of Interest Regulation relates not only to members but also to 'non-arm's length relationships'.

A professional's judgement must not be influenced by personal interest such as financial gain. For example, in recommending products to a patient, an optometrist cannot be influenced by promotions offered by a particular manufacturer. Recommendations must be based solely on what the optometrist believes is in the best interest of the patient. It is important to note that there doesn't need to be any actual influence or benefit to the practitioner, even the *perception* of a conflict constitutes a conflict of interest.

Part II Conflict of interest:

- considers benefits, referrals, financial interest and disclosure;
- prohibits fee sharing with anyone other than another optometrist or physician;
- describes business and working arrangements allowed to optometrists; and
- outlines the requirements for practice as an independent contractor.

The Conflict of Interest section requires that optometrists practicing as independent contractors do so with a written agreement which states that the optometrist,

> (a) shall control the professional services provided to a patient;
>
> (b) shall control who he or she may accept as a patient;
>
> (c) shall provide every patient or his or her authorized representative with a copy of his or her prescription;

(d) shall set the fee charged or collected in respect of any professional service;

(e) shall control the maintenance, custody and access to the records required to be kept in respect of the practice of the profession;

(f) shall have access, along with his or her staff, to the premises where the member practises and to the books and records related to his or her practice, at any time of the day or night; and

(g) shall ensure that any advertising relating to the professional services provided by the member meets the requirements set out in regulations made under the Act. O. Reg. 24/14, s. 1.

Records

The Records Regulations recognize three different types of records: the daily appointment record, financial records and patient health records. For financial records, the Regulation states that a record is required and that it must include the optometrist's the fees for services and any commercial laboratory costs charged to the optometrist. The Professional Misconduct Regulation also states that a receipt for a patient must show the fees for the services provided, including diagnostic or treatment (dispensing) fees.

Section 10 of the General Regulation outlines the required elements of the patient record. It must include information relating to patient identification and the date of the visit, the patient's relevant health history, procedures used during the examination, findings obtained and diagnoses made, information concerning referrals to and from the optometrist and, when appropriate, patient consent for services provided.

The regulation also specifies that records must be retained for ten years after the patient's last visit or ten years after they would have become 18 years of age if they were younger than 18 when they were last examined.

The regulation identifies to whom a record can be released. Confidentiality is an important tenet of the trust relationship between patient and practitioner. As a general rule, information obtained in the course of providing optometric care must remain confidential. Breach of confidentiality is considered to be professional misconduct. However, an optometrist is required to provide a copy of the record to the patient upon their request, or to their representative (more information regarding consent and the disclosure of personal health information can be found in the *Personal Health Information Protection Act*). A summary of the patient record may be provided if that is

requested, however the patient is entitled to a copy of their complete record. A fee related to reasonable cost recovery, may be charged for providing a copy of the record.

More information concerning the patient health record can be found in the Optometric Practice Reference.

Electronic Records

Members who maintain their records electronically, must produce complete financial records and patient health records (as defined by the regulation O. Reg 749/94, Part IV) upon request. In addition to the regulatory requirements, optometrists are expected to utilize reasonable and reliable backup systems. Where patient information is stored on mobile devices in an identifiable form, the information must be encrypted.

Quality Assurance

Every College is expected to have a Quality Assurance Program that:

- maintains and improves individual members' competence;
- raises the performance of the profession generally; and
- identifies and addresses members who are incompetent or unfit to practise.

The College's Quality Assurance Program includes the following components:

- mandatory continuing education
- an assessment component to appraise the practice of members
- an evaluation component to evaluate a member's clinical ability
- a remedial component to assist a member in correcting any deficiencies in the member's practice or clinical ability
- a component to assist in appraising the practice or evaluating the clinical ability of an applicant for registration when referred by the Registration Committee or the Registrar
- a component to provide for assessment and rehabilitation of a member who has allegedly exhibited inappropriate behaviour or made inappropriate remarks of a sexual nature towards a patient
- a component to obtain information from members to assist the Committee in carrying out the program's objects.

Continuing Education is one component in which all members of the College must participate. It is designed to encourage members to enhance their knowledge, skill and judgment. A commitment to lifelong learning is felt to be an appropriate strategy in order to keep pace with changes that are occurring in optometric knowledge. It is also necessary as the scope of practice of optometry expands.

The current continuing education policy of the College can be found in the Jurisprudence Resource Binder.

There are several ways a member of the College may find that he or she is required to complete a practice assessment:

- Each year, 5% of members are randomly selected to participate in an assessment
- The Discipline Committee can refer a member to QA for a practice assessment
- A member who fails to meet the CE requirement will be referred by the Registrar for a practice assessment
- A member who fails to meet the ongoing practice hour requirement will be referred by the Registrar for a practice assessment

For a random practice assessment, the steps are as follows:

- A member is notified that he or she has been randomly selected. At this time, a Practice Review Questionnaire is sent out.
- The member is given two months to send in the required 25 clinical records and return the Practice Assessment Questionnaire.
- An assessor conducts a short record assessment (SRA) and prepares a report for the QA Committee.
- The Committee reviews the report and the member is advised of the results of the committee's considerations.

The Regulation limits the number and nature of dispositions available to the Committee.

A copy of the short record assessment (SRA) and the complete record assessment (CRA) are available on the College website. Members are encouraged to review these forms and do their own periodic self-assessment.

Registration Regulation

Each college sets its own entry to practice requirements. In Ontario, an applicant must:

1. complete an application form;
2. meet the academic qualifications requirement;
3. be fluent in English or French;
4. provide proof of good standing from any jurisdiction where the applicant has previously practised any health profession;
5. have no criminal record;
6. provide proof of citizenship/permanent residency/authorization;
7. successfully complete the jurisprudence and CSAO/CACO examinations; and
8. pay the applicable fees

Recent amendments to the Registration Regulation address academic requirements for international graduates.

These requirements help ensure that the College meets the goal of the RHPA to protect the public from practitioners who are unqualified, unfit or unethical. That said, items 3, 4 and 5 are 'exemptible', i.e., there are certain situations when they may not be required. For example, the Registration Committee can exempt an applicant from the requirement that he or she must not have a criminal record. In making this determination, the Committee would consider a number of factors including the seriousness of the offence, the circumstances surrounding the offence, the recency of the finding of guilt, and the relevance of the offence to the practice of optometry or the applicant's suitability to be a member of the College.

Applicants applying from another province under the Labour Mobility provisions are to provide evidence that they have practised the profession of optometry to the extent that would be permitted by a General Certificate of Registration at any time in the three years immediately before the date of that applicant's application. If the applicant is unable to do so, he/she must meet any further requirement to undertake, obtain or undergo material additional training, experience, examinations or assessments that may be specified by a panel of the Registration Committee. Accordingly, these applicants must provide proof of being registered and to have practised in the Canadian province/territories from which they are applying.

Initially, the Registrar considers the application for registration. If the Registrar has doubts about whether or not the applicant meets the requirements (such as the applicant has a criminal record), or intends to refuse the application or to attach terms, conditions or limitations to the certificate of registration to which the applicant does not agree, the application is referred to the Registration Committee.

The applicant has the right to make written submissions to the Registration Committee with respect to the application. The Committee's decision may be appealed to the Health Professions Appeal and Review Board (HPARB). The appeals process is outlined in the Health Professions Procedural Code under the RHPA. The applicant may request HPARB to conduct either an oral hearing or a document review. The Board's decision may be appealed to the Divisional Court.

The Registration Regulation contains several conditions that must be fulfilled in order for a member to maintain their certificate of registration. One of those conditions relates to the member reporting to the College any adverse discipline findings in other jurisdictions, as well as any criminal convictions. The College believes that competence will diminish if a member is not practising on a regular basis. Accordingly, members must provide at least 750 hours of direct optometric care to patients in Canada in every three-year period following the year in which they are registered. They are also required to report their participation in continuing education activities.

Each year, members are required to complete an Annual Report Form and report on their direct patient care hours and continuing education. If the legislated requirements are not met, the member is referred to the Quality Assurance Committee for a practice assessment.

Optometry Act, 1991

S.O. 1991, CHAPTER 35

Consolidation Period: From October 29, 2015 to the e-Laws currency date.

Last amendment: 2015, c. 20, Sched. 15, s. 18.

Legislative History: 1998, c. 18, Sched. G, s. 40; 2007, c. 10, Sched. B, s. 17; 2009, c. 26, s. 20; 2015, c. 20, Sched. 15, s. 18.

Definitions

1 In this Act,

"College" means the College of Optometrists of Ontario; ("Ordre")

"Health Professions Procedural Code" means the Health Professions Procedural Code set out in Schedule 2 to the *Regulated Health Professions Act, 1991*; ("Code des professions de la santé")

"member" means a member of the College; ("membre")

"profession" means the profession of optometry; ("profession")

"this Act" includes the Health Professions Procedural Code. ("la présente loi") 1991, c. 35, s. 1.

Health Professions Procedural Code

2 (1) The Health Professions Procedural Code shall be deemed to be part of this Act.

Terms in Code

(2) In the Health Professions Procedural Code as it applies in respect of this Act,

"College" means the College of Optometrists of Ontario; ("ordre")

"health profession Act" means this Act; ("loi sur une profession de la santé")

"profession" means the profession of optometry; ("profession")

"regulations" means the regulations under this Act. ("règlements")

Definitions in Code

(3) Definitions in the Health Professions Procedural Code apply with necessary modifications to terms in this Act. 1991, c. 35, s. 2.

Scope of practice

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

(a) disorders of refraction;

(b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and

(c) prescribed diseases. 1991, c. 35, s. 3.

Authorized acts

4 In the course of engaging in the practice of optometry, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.
2. Applying a prescribed form of energy.

2.1 Prescribing drugs designated in the regulations.

3. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses. 1991, c. 35, s. 4; 2007, c. 10, Sched. B, s. 17 (1).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. B, s. 17 (1) - 04/06/2007

College continued

5 The College is continued under the name College of Optometrists of Ontario in English and Ordre des optométristes de l'Ontario in French. 1991, c. 35, s. 5.

Council

6 (1) The Council shall be composed of,

(a) at least eight and no more than nine persons who are members elected in accordance with the by-laws;

(b) at least seven and no more than eight persons appointed by the Lieutenant Governor in Council who are not,

(i) members,

(ii) members of a College as defined in the *Regulated Health Professions Act, 1991*, or

(iii) members of a Council as defined in the *Regulated Health Professions Act, 1991*; and

(c) one person selected, in accordance with a by-law made under section 12.1, from among members who are members of a faculty of optometry of a university in Ontario. 1991, c. 35, s. 6 (1); 1998, c. 18, Sched. G, s. 40 (1, 2).

Who can vote in elections

(2) Subject to the by-laws, every member who practises or resides in Ontario and who is not in default of payment of the annual membership fee is entitled to vote in an election of members of the Council. 1991, c. 35, s. 6 (2); 1998, c. 18, Sched. G, s. 40 (3).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 40 (1-3) - 01/02/1999

President and Vice-President

7 The Council shall have a President and Vice-President who shall be elected annually by the Council from among the Council's members. 1991, c. 35, s. 7.

8 REPEALED: 2015, c. 20, Sched. 15, s. 18.

Section Amendments with date in force (d/m/y)

2015, c. 20, Sched. 15, s. 18 - 29/10/2015

Restricted titles

9 (1) No person other than a member shall use the title "optometrist", a variation or abbreviation or an equivalent in another language.

Representations of qualification, etc.

(2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as an optometrist or in a specialty of optometry.

Definition

(3) In this section,

"abbreviation" includes an abbreviation of a variation. 1991, c. 35, s. 9.

Notice if suggestions referred to Advisory Council

10 (1) The Registrar shall give a notice to each member if the Minister refers to the Advisory Council, as defined in the *Regulated Health Professions Act, 1991*, a suggested,

(a) amendment to this Act;

(b) amendment to a regulation made by the Council; or

(c) regulation to be made by the Council.

Requirements re notice

(2) A notice mentioned in subsection (1) shall set out the suggestion referred to the Advisory Council and the notice shall be given within thirty days after the Council of the College receives the Minister's notice of the suggestion. 1991, c. 35, s. 10.

Offence

11 Every person who contravenes subsection 9 (1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence. 2007, c. 10, Sched. B, s. 17 (2).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. B, s. 17 (2) - 04/06/2007

Regulations

12 (1) Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations,

(a) specifying the drugs that a member may use in the course of engaging in the practice of optometry;

(b) designating drugs for the purposes of paragraph 2.1 of section 4;

(c) regulating and governing the prescribing or using of drugs by members and ancillary matters, including, without limiting the generality of the foregoing,

(i) governing the purposes for which, or the circumstances under which, drugs may be prescribed or used,

(ii) setting requirements respecting the prescribing or using of drugs, and

(iii) setting prohibitions. 2007, c. 10, Sched. B, s. 17 (3); 2009, c. 26, s. 20 (1).

Individual drugs or categories

(2) A regulation made under clause (1) (a) or (b) may specify or designate individual drugs or categories of drugs. 2009, c. 26, s. 20 (2).

Incorporation by reference

(3) A regulation made under clause (1) (a) or (b) may adopt, by reference, in whole or in part, and with such changes as are considered necessary, one or more documents setting out a list of individual drugs or a list of categories of drugs that may be prescribed by members. 2009, c. 26, s. 20 (2).

Rolling incorporation

(4) If a regulation provided for in subsection (3) so provides, a document adopted by reference shall be a reference to it as amended from time to time after the making of the regulation. 2009, c. 26, s. 20 (2).

Must be made by expert committee

(5) A document adopted by reference under subsection (3) may only be a document created or approved by an expert committee established under section 43.2 of the *Regulated Health Professions Act, 1991* and no other body. 2009, c. 26, s. 20 (2).

Availability

(6) A document adopted by reference under subsection (3) must be named in the regulation and must be available for public inspection during normal business hours in the office of the College and must be posted on the College's website or available through a hyperlink at the College's website. 2009, c. 26, s. 20 (2).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 40 (4) - 01/02/1999

2007, c. 10, Sched. B, s. 17 (3) - 04/06/2007

2009, c. 26, s. 20 (1, 2) - 15/12/2009

By-laws

12.1 The Council may make by-laws respecting the qualifications, selection and terms of office of Council members who are selected. 1998, c. 18, Sched. G, s. 40 (4).

Section Amendments with date in force (d/m/y)

1998, c. 18, Sched. G, s. 40 (4) - 01/02/1999

Transitional

13 A person who, on the day before this Act comes into force, held a licence issued under Part V of the *Health Disciplines Act* shall be deemed to be the holder of a certificate of registration issued under this Act subject to any term, condition or limitation to which the licence was subject. 1991, c. 35, s. 13.

14 REPEALED: 2007, c. 10, Sched. B, s. 17 (4).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. B, s. 17 (4) - 04/06/2007

15 REPEALED: 2007, c. 10, Sched. B, s. 17 (4).

Section Amendments with date in force (d/m/y)

2007, c. 10, Sched. B, s. 17 (4) - 04/06/2007

16 OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS ACT). 1991, c. 35, s. 16.

17 OMITTED (ENACTS SHORT TITLE OF THIS ACT). 1991, c. 35, s. 17.

Optometry Act, 1991
Loi de 1991 sur les optométristes

ONTARIO REGULATION 112/11

DESIGNATED DRUGS AND STANDARDS OF PRACTICE

Last amendment: O. Reg. 17/17.

This Regulation is made in English only.

PART I
PRESCRIPTIONS

Drugs that may be prescribed

1. For the purposes of paragraph 2.1 of section 4 of the Act, and subject to sections 2, 3 and 4 and Part II of this Regulation, a member may prescribe a drug set out under a category and sub-category heading in Schedule 1.

Limitation

2. Where a limitation or a route of administration is indicated in the sub-category heading set out in Schedule 1, a member shall only prescribe a drug listed under that sub-category in compliance with the limitation and in accordance with the route of administration specified.

Training required

3. No member may prescribe any drug unless he or she has successfully completed the relevant training in pharmacology that has been approved by the Council.

Recording

4. Every time a member prescribes a drug the member shall record the following in the patient's health record as that record is required to be kept under section 10 of Ontario Regulation 119/94 (General) made under the Act:

1. Details of the prescription, including the drug prescribed, dosage and route of administration.
2. Details of the counselling provided by the member to or on behalf of the patient respecting the use of the drug prescribed.

Non-prescription drugs

5. In the course of engaging in the practice of optometry a member may prescribe any drug that may lawfully be purchased or acquired without a prescription. O. Reg. 112/11, s. 5.

PART II
STANDARDS OF PRACTICE — GLAUCOMA

Prescribing of antiglaucoma agents

6. It is a standard of practice of the profession that in treating glaucoma a member may only prescribe a drug set out under the category of "Antiglaucoma Agents" in Schedule 1.

Open-angle glaucoma

7. (1) Subject to subsection (2) and to section 8, it is a standard of practice of the profession that a member may only treat a patient with glaucoma where the patient has primary open-angle glaucoma the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment.

(2) It is a standard of practice of the profession that a member may only treat a patient having open-angle glaucoma, the treatment of which is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment, in collaboration with a physician with whom the member has established a co-management model of care for that patient and who is,

(a) certified by the Royal College of Physicians and Surgeons of Canada as a specialist in ophthalmology; or

(b) formally recognized in writing by the College of Physicians and Surgeons of Ontario as a specialist in ophthalmology.

Referral to physician or hospital

8. (1) Subject to subsections (2) and (3), it is a standard of practice of the profession that a member shall immediately refer a patient having a form of glaucoma other than primary open-angle glaucoma to a physician or to a hospital.

(2) It is a standard of practice of the profession that a member may initiate treatment for a patient having angle-closure glaucoma only in an emergency and where no physician is available to treat the patient.

(3) It is a standard of practice of the profession that a member shall immediately refer any patient being treated in accordance with subsection (2) to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

(4) In this section,

"hospital" means a hospital within the meaning of the *Public Hospitals Act.*

9. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS REGULATION). Reg. 112/11, s. 9.

SCHEDULE 1

ANTI-INFECTIVE AGENTS

Antibacterials (topical)

- azithromycin
- besifloxacin
- ciprofloxacin
- erythromycin
- framycetin
- fusidic acid
- gatifloxacin
- gentamicin
- moxifloxacin
- ofloxacin
- polymyxin B/gramicidin/neomycin
- polymyxin B/neomycin/ bacitracin
- polymyxin B/trimethoprim
- sulfacetamide
- tetracycline
- tobramycin

Antifungals (topical)

- natamycin

Antivirals (topical)

- trifluridine
- Acyclovir

Antibacterials (oral) – for corneal or eyelid infections only and for a duration not exceeding 14 days

- amoxicillin
- amoxicillin/clavulanic acid
- azithromycin
- cephalexin
- ciprofloxacin

clarithromycin
clindamycin
cloxacillin
doxycycline
erythromycin
levofloxacin
minocycline
moxifloxacin
tetracycline

Antivirals (oral) – for corneal or eyelid infections only

acyclovir
famciclovir
valacyclovir

ANTI-INFLAMMATORY AGENTS

Corticosteroids (topical)

dexamethasone
difluprednate
fluorometholone
loteprednol
prednisolone
rimexolone

Corticosteroids (topical) – for the purpose of treating conditions of the eye and adnexa

triamcinolone

Immunomodulators (topical)

cyclosporine

Nonsteroidal anti-inflammatory agents (topical)

bromfenac
diclofenac
ketorolac
nepafenac

ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS

Antibacterials /corticosteroids (topical)

framycetin/gramicidin/dexamethasone

gentamicin/betamethasone

neomycin/fluorometholone

neomycin/polymyxin B/dexamethasone

neomycin/bacitracin/polymyxin B/hydrocortisone

sulfacetamide/prednisolone

tobramycin/dexamethasone

MYDRIATICS

Mydriatics (topical)

atropine

cyclopentolate

homatropine

tropicamide

ANTI-ALLERGIC AGENTS

Antiallergic agents (topical)

bepotastine

emedastine

ketotifen

levocabastine

lodoxamide

nedocromil

olopatadine

tacrolimus – for the purpose of treating conditions of the eye and adnexa and for a duration not exceeding 42 days

ANTIGLAUCOMA AGENTS

β-Adrenergic blocking agents (topical)

betaxolol

levobunolol

timolol

Carbonic anhydrase inhibitors (topical)

brinzolamide

dorzolamide

Miotics (topical)

carbachol

pilocarpine

Prostaglandin analogs (topical)

bimatoprost

latanoprost

tafluprost

travoprost

α-Adrenergic agonists (topical)

apraclonidine

brimonidine

α-Adrenergic agonists/β-adrenergic blocking agents (topical)

brimonidine/timolol

Carbonic anhydrase inhibitors/β-adrenergic blocking agents (topical)

brinzolamide/timolol

dorzolamide/timolol

Prostaglandin analogs/β-adrenergic blocking agents (topical)

latanoprost/timolol

travoprost/timolol

Carbonic anhydrase inhibitors (oral) – to lower intraocular pressure only and a member shall immediately refer the patient to a physician or to a hospital

acetazolamide

SECRETAGOGUES

Secretagogues (oral) – for Sjögren's syndrome only and only in collaboration with a physician with whom the member has established a co-management model of care

pilocarpine

O. Reg. 112/11, Sched. 1; O. Reg. 17/17, s. 2.

Optometry Act, 1991
ONTARIO REGULATION 119/94

GENERAL

This Regulation is made in English only.

Part I
PROFESSIONAL MISCONDUCT

1. The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:
THE PRACTICE OF THE PROFESSION AND THE CARE OF, AND RELATIONSHIP WITH, PATIENTS

1. Contravening a term, condition or limitation to which the member's certificate of registration is subject.
2. Exceeding the scope of practice of the profession.
3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
4. Abusing a patient verbally or physically.
5. Practising the profession while the member's ability to do so is impaired by any substance.
6. Discontinuing professional services that are needed unless,
    i. the patient requests the discontinuation,
    ii. the member arranges alternative services,
    iii. the patient is given a reasonable opportunity to arrange alternative services, or
    iv. the patient has failed to make payment within a reasonable time for services received, and the services that are needed are not of an emergency nature.
7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.
8. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a patient's request to do so.
9. Making a misrepresentation with respect to a remedy, treatment or device.
10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes

or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.
13. Recommending or providing unnecessary diagnostic or treatment services.
14. Failing to maintain the standards of practice of the profession.
15. Delegating a controlled act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
16. Performing a controlled act that the member is not authorized to perform.
17. Permitting, counselling or assisting a person who is under the supervision of a member to perform an act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
18. Permitting, counselling or assisting any person who is not a member to perform a controlled act which should be performed by a member.

REPRESENTATIONS ABOUT MEMBERS AND THEIR QUALIFICATIONS

19. Using a term, title or designation in respect of the member's practice other than "optometrist" or "doctor of optometry".
20. Using, in the course of providing or offering to provide professional services, any reference to the member's education or educational achievement other than the member's university degree, unless the use of the reference is approved by Council.
21. Identifying oneself to a patient as a person who is qualified to practise as a member of a health profession other than optometry, unless lawfully entitled to do so in Ontario under the legislation governing that profession.
22. Publishing or using, or knowingly permitting the publication or use of an advertisement or announcement or information that promotes or relates to the provision of professional services by a member to the public, whether in a document, business card, business sign, website, or any other format, which,
    i. is false or deceptive, whether by reason of inclusion of or omission of information,
    ii. suggests that the member is a specialist or is specially educated, trained or qualified other than where the reference is to an educational achievement and the reference has been approved by Council,
    iii. contains a testimonial or comparative or superlative statements,
    iv. contains an endorsement other than an endorsement by an individual or organization that has demonstrated, to the satisfaction of Council, that the individual or organization has expertise relevant to the subject matter of the endorsement,

v. is not factual, objectively verifiable or readily comprehensible to the persons to whom it is directed, or

vi. would be reasonably regarded by members as demeaning the integrity or dignity of the profession or likely to bring the profession into disrepute.

23. Where a member uses, in the course of providing or offering to provide professional services, a name other than the name of the member as it is published on the register of the College, failing to,

    i. post a list, in a location where patients will likely see it, of the name of every member who practises at that location,

    ii. notify the Registrar in writing of the name of every member who practises at that location, and

    iii. notify the Registrar in writing of any change in the members who practise at that location no less than 30 days from the date that the change occurred.

RECORD KEEPING AND REPORTS

24. Failing to make or maintain records in accordance with Part IV.

25. Falsifying a record relating to a member's practice.

26. Signing or issuing, in the member's professional capacity, a certificate, report or similar document that contains a statement the member knows or ought to know is false, misleading or otherwise improper, or omits statements or information that the member knows or ought to know should be included.

27. If a member closes his or her office or retires from practice, failing to make reasonable efforts to make arrangements with a patient or his or her authorized representative to transfer the patient's records to,

    i. the patient or his or her authorized representative,

    ii. another member, if the patient or his or her authorized representative so requests, or

    iii. another member, with notice to the patient that his or her records have been transferred to that other member.

BUSINESS PRACTICES

28. Submitting or allowing to be submitted an account for professional services that the member knows or ought to know is false or misleading.

29. Charging or allowing a fee to be charged that is excessive or unreasonable in relation to the professional services provided.

30. Failing to issue a statement or receipt that itemizes an account for professional goods or services to the patient or a third party who is to pay, in whole or in part, for the goods or services provided to the patient.

31. Charging or receiving more than the amount payable under the Ontario Health Insurance Plan for performing an insured service to an insured person.

32. Accepting payment in respect of an insured service to an insured person before the member receives notice from the Ontario Health Insurance Plan that the patient has been reimbursed by the Plan, unless the insured person has consented to make the payment on an earlier date.
33. Charging or accepting a fee, in whole or in part, before providing professional services to a patient unless,
    i. the fee relates to the cost of professional goods to be used in the course of performing the services, or,
    ii. the member informs the patient, before he or she pays the fee, of the patient's right to choose not to pay the fee before the professional services are performed.

MISCELLANEOUS MATTERS

34. Failing to comply with an order of the Inquiries, Complaints and Reports Committee requiring the member to appear before a panel of the committee to be cautioned.
35. Failing to abide by a written undertaking given by the member to the College or a Committee, or to carry out an agreement entered into with the College or a Committee.
36. Contravening, by act or omission, the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
37. Failing to co-operate with a representative of another College on production of an appointment under section 75 of the Health Professions Procedural Code or to provide access to or copies of a record, document or thing that may be reasonably required for the purposes of an investigation.
38. Failing to provide a patient or a patient's authorized representative, when requested, with the practice address and telephone number of a member who previously practised with the member when the member knows or ought to know this information.
39. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical. O. Reg. 24/14, s. 1.

PART II
CONFLICT OF INTEREST

2. In this Part,

"benefit" means any incentive of more than nominal value and includes a rebate, credit or gift but does not include a reasonable discount based on volume or prompt payment;

"health centre" means a facility that provides health services funded by the Ministry of Health and Long-Term Care;

"non-arm's length relationship" means a relationship other than that between parties who are unrelated, with each acting in his or her own best interest in the ordinary course of business. O. Reg. 24/14, s. 1.

3. (1) A member shall not engage in the practice of the profession while the member is in a conflict of interest. O. Reg. 24/14, s. 1.

(2) A member is in a conflict of interest where the member,

(a) has a personal or financial interest that influences or is likely to influence the exercise of the member's professional expertise or judgment in respect of the treatment or referral of a patient;

(b) enters into an arrangement or agreement that influences or is likely to influence the member's ability to properly exercise his or her professional expertise or judgment in respect of the treatment or referral of a patient;

(c) offers or confers a benefit to a person in connection with the referral of a patient to the member;

(d) accepts a benefit that is related to the member referring a patient to any other person;

(e) accepts or confers a benefit relating to any ophthalmic materials, appliances or equipment, that influences or is likely to influence the exercise of the member's professional judgment respecting the purchase or use of the materials, appliances or equipment;

(f) enters into any arrangement or agreement respecting a lease or the use of premises or equipment used in the practice of the profession under which any amount payable is related to the amount of fees charged or the volume of business carried out by the member;

(g) subject to subsection 4 (5), engages in the practice of the profession in a working arrangement with another person except,

(i) with a member who is engaged in the practice of the profession,

(ii) with a member of the College of Physicians and Surgeons of Ontario who is engaged in the practice of medicine,

(iii) as an employee or agent of a government or government agency, health centre, university or hospital,

(iv) as an employee of a corporation, other than one referred to in subclause (iii) for the purpose of providing services solely to the employees of that corporation, or

(v) under an arrangement approved by Council;

(h) shares fees related to the practice of the profession with any person other than,

(i) another member, or

(ii) a member of the College of Physicians and Surgeons of Ontario engaged in the practice of medicine. O. Reg. 24/14, s. 1.

4. (1) Despite clause 3 (2) (a), a member is not in a conflict of interest if the member discloses to the patient the nature of the member's personal or financial interest to the patient before providing professional services. O. Reg. 24/14, s. 1.

(2) A member is not in a conflict of interest in connection with making a recommendation about the referral of a patient that has the potential to benefit a person who is in a non-arm's length relationship with the member, if the member receives no benefit for the referral and if, before making the recommendation, the member discloses to the patient the nature of the relationship between the member and the person who is in a non-arm's length relationship with the member. O. Reg. 24/14, s. 1.

(3) A member is not in a conflict of interest in connection with the member receiving a patient referred from a person who is in a non-arm's length relationship with the member if the member receives no benefit in relation to the referral and if, before providing professional services, the member discloses to the patient the nature of the relationship between the member and the person who is in a non-arm's length relationship with the member. O. Reg. 24/14, s. 1.

(4) A member is not required to disclose his or her financial interest in an optometry professional corporation in which he or she is a shareholder in order to obtain the benefit of subsection (1), (2) or (3) if the fact that the member engages in the practice of optometry in an optometry professional corporation was made known to the patient. O. Reg. 24/14, s. 1.

(5) No conflict of interest arises under clause 3 (2) (g) where the member engages in the practice of the profession as an independent contractor with another person in accordance with a written agreement that states that the member,

(a) shall control the professional services provided to a patient;

(b) shall control who he or she may accept as a patient;

(c) shall provide every patient or his or her authorized representative with a copy of his or her prescription;

(d) shall set the fee charged or collected in respect of any professional service;

(e) shall control the maintenance, custody and access to the records required to be kept in respect of the practice of the profession;

(f) shall have access, along with his or her staff, to the premises where the member practises and to the books and records related to his or her practice, at any time of the day or night; and

(g) shall ensure that any advertising relating to the professional services provided by the member meets the requirements set out in regulations made under the Act. O. Reg. 24/14, s. 1.

(6) For the purpose of subsection (5),

"independent contractor" means a person who practises the profession under an agreement with another, but who is independent and not controlled by the other or subject to the other's right to control respecting the member's conduct in the practice of the profession. O. Reg. 24/14, s. 1.

5. Revoked: O. Reg. 56/00, s. 1.

PART III (s. 6) Revoked: O. Reg. 56/00, s. 1.

PART IV
RECORDS

7. (1) A member shall take all reasonable steps necessary to ensure that records in relation to his or her practice are kept in accordance with this Part. O. Reg. 749/94, s. 3.

(2) Reasonable steps under subsection (1) shall include the verification by the member, at reasonable intervals, that the records are kept in accordance with this Part. O. Reg. 749/94, s. 3.

8. Every member shall keep a daily appointment record that sets out the name of each patient whom the member examines or treats or to whom the member provides any service. O. Reg. 749/94, s. 3.

9. (1) Every member shall keep a financial record for each patient. O. Reg. 749/94, s. 3.

(2) The financial record must include the member's fees for services and any commercial laboratory costs charged to the member. O. Reg. 749/94, s. 3.

10. (1) Every member shall keep a patient health record for each patient. O. Reg. 749/94, s. 3.

(2) The patient health record must include the following:

1. The name and address of the patient and the name of the member who provided the service.

2. The date of each visit of the patient.

3. The name and address of any referring health professional.

4. The patient's health and oculo-visual history.

5. The clinical procedures used.

6. The clinical findings obtained.

7. The diagnosis, when possible.

8. Every order made by the member for examinations, tests, consultations or treatments to be performed by any other person.

9. Particulars of every referral to or from another health professional.

10. Information about every delegation of a controlled act within the meaning of subsection 27 (2) of the *Regulated Health Professions Act, 1991*, delegated by the member.

11. Information about a procedure that was commenced but not completed, including reasons for non-completion.

12. A copy of every written consent to treatment. O. Reg. 749/94, s. 3.

(3) Every part of a patient health record must be dated and have a reference identifying the patient or the patient health record. O. Reg. 749/94, s. 3.

(4) Every entry in the patient health record must be dated and the person who made the entry must be readily identifiable. O. Reg. 749/94, s. 3.

(5) Every patient health record shall be retained for at least 10 years following,

(a) the patient's last visit; or

(b) if the patient was less than 18 years old at the time of his or her last visit, the day the patient became or would have become 18 years old. O. Reg. 749/94, s. 3.

11. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

1. Allowing any person to examine a patient health record or giving a copy of a document or any information from a patient health record to any person except as required by law or as required or allowed by this section.

2. Failing to provide copies from a patient health record for which the member has primary responsibility, as required by this section. O. Reg. 749/94, s. 3.

(2) A member shall provide copies from a patient health record for which the member has primary responsibility to any of the following persons on request:

1. The patient.

2. A personal representative who is authorized by the patient to obtain copies from the record.

3. If the patient is dead, the patient's legal representative.

4. If the patient lacks capacity to give an authorization described in paragraph 2,

i. a committee of the patient appointed under the *Mental Incompetency Act*,

ii. a person to whom the patient is married,

iii. a person of the opposite or same sex, with whom the patient is living in a conjugal relationship outside marriage, if the patient and the person,

A. have cohabited for at least one year,

B. are together the parents of a child, or

C. have together entered into a cohabitation agreement under section 53 of the *Family Law Act*,

iv. the patient's son or daughter,

v. the patient's parent. O. Reg. 749/94, s. 3.

(3) It is not an act of professional misconduct under paragraph 2 of subsection (1) for a member to refuse to provide copies from a patient health record until the member is paid a reasonable fee. O. Reg. 749/94, s. 3.

(4) A member may provide copies from a patient health record for which the member has primary responsibility to any person authorized by or on behalf of a person to whom the member is required to provide copies under subsection (2). O. Reg. 749/94, s. 3.

(5) A member may, for the purposes of providing health care, allow a health professional to examine the patient health record or give a health professional a copy of a document or any information from the record. O. Reg. 749/94, s. 3.

12. For record keeping required by this Part, a member may use computer, electronic or other equipment for recording, storing and retrieval of records if,

(a) the record keeping system provides ready access by an authorized investigator, inspector or assessor of the College, or the patient or the patient's representative to the records;

(b) ancillary equipment is readily available for the making of hard copies of the record at no expense to an authorized investigator, inspector or assessor of the College;

(c) the equipment or software being used is such that no amendment, correction, addition or deletion can be made to any record which obliterates the original record or does not show the date of the change. O. Reg. 749/94, s. 3.

PARTS V-VII (ss. 13-20) Revoked: O. Reg. 56/00, s. 1.

PART VIII
PRESCRIBED DISEASES

21. For the purposes of clause 3 (c) of the *Optometry Act, 1991*, the following are prescribed diseases:

1. In relation to diagnosis and prevention, diseases of the eye and vision system that can be determined by the findings from an oculo-visual assessment.

2. In relation to treatment, diseases of the eye and vision system that can be treated by other than the application of surgery. O. Reg. 152/97, s. 1.

22. For the purposes of paragraph 1 of section 4 of the *Optometry Act, 1991*, a "prescribed disease" is any disease limited to and manifested in the eye and vision system that was determined by the findings from an oculo-visual assessment. O. Reg. 152/97, s. 1.

PART IX
QUALITY ASSURANCE

Definitions

23. In this Part,

"assessor" means an assessor appointed under section 81 of the Health Professions Procedural Code;

"clinical ability" means, in relation to a member, the member's knowledge, skills and judgment relating to practising optometry;

"Committee" means the Quality Assurance Committee;

"deficiencies in the member's practice" means one or more aspects of the member's practice that are not in accordance with the standards of practice of the profession;

"deficient clinical ability" means, in relation to a member, a level of knowledge, skills or judgment that makes the member's clinical performance unsatisfactory;

"remedial program" means a specific education program that a member is required to undertake for the purpose of correcting deficient clinical ability. O. Reg. 250/99, s. 2.

Quality Assurance Program: Objects and Components

24. The objects of the quality assurance program, which is administered by the Committee, are to maintain and enhance the knowledge, skills and judgment of members so that appropriate care of high quality is provided to the public. O. Reg. 250/99, s. 2.

25. The quality assurance program shall include the following components:

1. A mandatory continuing education component.

2. An assessment component to appraise the practice of members.

3. An evaluation component to evaluate a member's clinical ability.

4. A remedial component to assist a member in correcting any deficiencies in the member's practice or clinical ability.

5. A component to assist in appraising the practice or evaluating the clinical ability of an applicant for registration when referred by the Registration Committee or the Registrar.

6. A component to provide for assessment and rehabilitation of a member who has allegedly exhibited inappropriate behaviour or made inappropriate remarks of a sexual nature towards a patient.

7. A component to obtain information from members to assist the Committee in carrying out the program's objects. O. Reg. 250/99, s. 2.

Mandatory Continuing Education

26. (1) Every member shall participate in a mandatory continuing education program established and administered by the Committee. O. Reg. 250/99, s. 2.

(2) The requirements of the program and any changes to them shall be approved by the Council, published by the College and distributed to the members. O. Reg. 250/99, s. 2.

Practice Assessment

27. (1) A member is required to undergo a practice assessment if,

(a) the member's name is selected at random in accordance with the random sampling process approved by the Council, published by the College and distributed to the members;

(b) the member is referred to the Committee by the Registrar pursuant to subsection 8 (2) of Ontario Regulation 837/93; or

(c) the member is referred to the Committee by the Complaints Committee, Discipline Committee or Executive Committee. O. Reg. 250/99, s. 2.

(2) An assessment shall include the inspection and assessment of the member's records of the care of patients and other records required to be maintained under the regulations under the Act, and may include, but is not limited to, an inspection of the member's office or offices and requiring the member to respond to a practice questionnaire. O. Reg. 250/99, s. 2.

(3) A written report shall be prepared in relation to the assessment of a member's practice. O. Reg. 250/99, s. 2.

(4) The Committee shall provide a copy of the report to the member and notify the member in writing of the right to make written submissions provided under subsection (5). O. Reg. 250/99, s. 2.

(5) A member who receives a report under subsection (4) may make written submissions to the Committee within 14 days after receiving the report. O. Reg. 250/99, s. 2.

(6) The Committee may, after considering an assessment report, any other information that the Committee considers relevant to the assessment and the member's written submissions, if any, decide,

(a) that no further action is required; or
(b) that there are deficiencies in the member's practice. O. Reg. 250/99, s. 2.

(7) If the Committee determines that there are deficiencies in the member's practice, the Committee shall,

(a) make written recommendations to the member on ways to correct the deficiencies and give the member an opportunity to correct them;

(b) subject to section 29, require the member to successfully complete within the time specified by the Committee continuing education activities approved by the Committee to assist in the correction of deficiencies in the member's practice; or

(c) subject to section 29, require the member to undergo an evaluation of the member's clinical ability. O. Reg. 250/99, s. 2.

(8) If the Committee acts under clause (7) (a) and the member has had an opportunity to correct the deficiencies, the Committee may require the member to undergo a reassessment of the practice, and subsections (2), (3), (4), (5), (6) and (7) apply to the reassessment. O. Reg. 250/99, s. 2.

(9) If the Committee acts under clause (7) (b), the Committee,

(a) may require the member to undergo a reassessment of the practice before the completion of the continuing education activities; and
(b) shall require the member to undergo a reassessment of the practice after completion of the continuing education activities. O. Reg. 250/99, s. 2.

(10) Subsections (2), (3), (4), (5), (6) and (7) apply to a reassessment under subsection (9). O. Reg. 250/99, s. 2.

(11) The Committee may not require more than two reassessments under this section. O. Reg. 250/99, s. 2.

Evaluation of Member's Clinical Ability

28. (1) If the Committee requires a member to undergo an evaluation of his or her clinical ability under clause 27 (7) (c), the Committee shall appoint a person or persons to carry out the evaluation. O. Reg. 250/99, s. 2.

(2) The evaluation may include,

(a) requiring the member to answer, orally or in writing, questions that relate to practising optometry;

(b) requiring the member to answer, orally or in writing, questions that arise from a review of real or simulated patient charts;

(c) requiring the member to examine persons or clinical simulations exhibiting problems that relate to practising optometry; and

(d) requiring the member to demonstrate the application of optometric techniques. O. Reg. 250/99, s. 2.

(3) The person or persons shall prepare a written report and submit it to the Committee. O. Reg. 250/99, s. 2.

(4) After receiving the report, the Committee shall provide a copy of the report to the member and notify the member in writing of the right to make written submissions provided under subsection (5). O. Reg. 250/99, s. 2.

(5) A member who receives a report under subsection (4) may make written submissions to the Committee within 14 days after receiving the report. O. Reg. 250/99, s. 2.

(6) After considering the evaluation report, the assessment report, other information the Committee considers relevant to the evaluation and the member's written submissions, if any, the Committee may decide,

(a) that the deficiencies in the member's practice were not the result of deficient clinical ability; or

(b) that the member has deficient clinical ability. O. Reg. 250/99, s. 2.

(7) If the Committee decides that the deficiencies in the member's practice are not the result of deficient clinical ability, it may,

(a) make written recommendations to the member on ways to correct the deficiencies in the member's practice and give the member an opportunity to correct them; or

(b) subject to section 29, require the member to successfully complete within the time specified by the Committee continuing education activities approved by the Committee to assist in the correction of deficiencies in the member's practice. O. Reg. 250/99, s. 2.

(8) If the Committee decides that the member has deficient clinical ability, it may,

(a) make written recommendations to the member on ways to correct the deficiencies and give him or her an opportunity to correct them; or

(b) subject to section 29, require the member to complete a remedial program approved by the Committee, within the time specified by the Committee; or

(c) subject to section 29 and subsection 30 (1), direct the Registrar to impose terms, conditions or limitations on the member's certificate of registration for a specified period not exceeding six months. O. Reg. 250/99, s. 2.

(9) If the Committee acts under clause (7) (a) or (8) (a) and the member has had an opportunity to correct the deficiencies, the Committee may require the member to undergo a reassessment of the practice, and subsections 27 (2), (3), (4), (5), (6) and (7) apply to the reassessment. O. Reg. 250/99, s. 2.

(10) At such time as it determines after the member has completed the continuing education activities required under clause (7) (b) or the remedial program required under clause (8) (b), the Committee may require the member to undergo a reassessment of the practice, and subsections 27 (2), (3), (4), (5), (6) and (7) apply to the reassessment. O. Reg. 250/99, s. 2.

(11) If the Committee takes action under subsection (8) and the member has had an opportunity to correct the deficiencies, completed or had the opportunity to complete a remedial program or had terms, conditions or limitations placed on his or her certificate of registration under this section, the Committee may require the member to undergo a re-evaluation, and the provisions of this section apply with necessary modifications to such a re-evaluation. O. Reg. 250/99, s. 2.

(12) The Committee may not require more than two reassessments under each of subsections (9) and (10) and more than one re-evaluation under subsection (11). O. Reg. 250/99, s. 2.

29. (1) The Committee shall not take action under clause 27 (7) (b) or (c), clause 28 (7) (b) or clause 28 (8) (b) or (c) unless it gives the member,

(a) written notice that, in the Committee's opinion, there are deficiencies in the member's practice or that the member has deficient clinical ability;
(b) a copy of all reports and other documents that the Committee considered in forming its opinion;
(c) at least 14 days after receiving the notice to make written submissions to the Committee; and
(d) if the member so requests in writing within 14 days after receiving the notice, an opportunity to confer with the Committee. O. Reg. 250/99, s. 2.

(2) After considering any submissions, whether written or oral, the Committee shall decide what action to take and, if it decides to take action under the provisions referred to in subsection (1), shall forward its written decision, with reasons, to the member. O. Reg. 250/99, s. 2.

Imposition of Terms, Conditions or Limitations on a Member's Certificate of Registration

30. (1) Subject to subsection (4), the Committee may direct the Registrar to impose terms, conditions or limitations on the member's certificate of registration for a specified period not exceeding six months if,

(a) the Committee decides that the member has deficient clinical ability; or
(b) the member has failed to successfully complete a remedial program within the period of time specified by the Committee. O. Reg. 250/99, s. 2.

(2) If the Committee has given a direction under subsection (1), it may give another direction for a second specified period not exceeding six months but it may not give a third direction for a further period of time. O. Reg. 250/99, s. 2.

(3) The Committee may direct the Registrar to remove any of the terms, conditions or limitations that have been imposed before the end of the period if it is satisfied that the member's knowledge, skills and judgment are satisfactory. O. Reg. 250/99, s. 2.

(4) The Committee shall not direct the Registrar under subsection (1) unless the member has been given,

(a) notice of the Committee's intention to direct the Registrar and of the reasons it believes the direction should be given;

(b) a copy of all reports and other documents that have been considered by the Committee in connection with the matter;

(c) at least 30 days after receiving the notice under clause (a) to make written submissions to the Committee; and

(d) if the member makes such a request in writing within 30 days after receiving the notice, an opportunity to confer with the Committee. O. Reg. 250/99, s. 2.

Applicants for Registration

31. (1) If a person is applying for registration, the Committee shall, on the request of the Registration Committee or the Registrar, review the applicant's patient records and any other records the Committee considers appropriate in order to assess the applicant's ability to practise in accordance with the standards of practice in Ontario. O. Reg. 250/99, s. 2.

(2) An assessor appointed by the Committee may assist it with the review. O. Reg. 250/99, s. 2.

(3) The Committee shall provide a written report of the results of its review to the Registrar, or to the Registration Committee if the latter requested the review. O. Reg. 250/99, s. 2.

(4) The Registrar shall provide a copy of the report to the applicant. O. Reg. 250/99, s. 2.

32. (1) If a person is applying for registration to practise, the Committee shall, on the request of the Registration Committee or the Registrar, ensure that an evaluation of the applicant's clinical ability is carried out. O. Reg. 250/99, s. 2.

(2) The Committee shall appoint a person or persons to carry out the evaluation. O. Reg. 250/99, s. 2.

(3) The evaluation may include,

(a) requiring the applicant to answer, orally or in writing, questions that relate to practising optometry;
(b) requiring the applicant to answer, orally or in writing, questions that arise from the review of real or simulated patient charts;
(c) requiring the applicant to examine persons or clinical simulations exhibiting problems that relate to practising optometry; and
(d) requiring the applicant to demonstrate the application of optometric techniques. O. Reg. 250/99, s. 2.

(4) The person or persons shall prepare a written report and submit it to the Committee. O. Reg. 250/99, s. 2.

(5) The Committee shall provide a written evaluation of the results of its review to the Registrar, or to the Registration Committee if the latter requested the review. O. Reg. 250/99, s. 2.

(6) The Registrar shall provide a copy of the evaluation to the applicant. O. Reg. 250/99, s. 2.

Measures Following Alleged Behaviour or Remarks of a Sexual Nature

33. (1) The Committee may require a member to undergo a psychological assessment or other assessment specified by the Committee if a matter respecting the member is referred to the Committee,

(a) by a panel of the Complaints Committee acting under paragraph 4 of subsection 26 (2) of the Health Professions Procedural Code with respect to

clause (c) of the definition of "sexual abuse" in subsection 1 (3) of the Code; or

(b) by the Executive Committee, the Complaints Committee or the Board under section 79.1 of the Code. O. Reg. 250/99, s. 2.

(2) The Committee may require a member to undertake and complete within a specified time a measure specified by the Committee, such as education, therapy or counselling, if,

(a) the Committee has received a report of an assessment of a member required by the Committee under subsection (1); and

(b) the Committee is satisfied that the member suffers from an emotional or personality condition that may adversely affect his or her professional behaviour. O. Reg. 250/99, s. 2.

(3) The Committee shall not take action under subsection (2) unless it gives the member,

(a) a copy of the report of the assessment;

(b) written notice of the measure the Committee intends to require;

(c) at least 14 days after receiving the notice to make written submissions to the Committee; and

(d) if the member so requests in writing within 14 days after receiving the notice, an opportunity to confer with the Committee. O. Reg. 250/99, s. 2.

(4) Subject to subsection (5), the Committee may direct the Registrar to impose terms, conditions or limitations on a member's certificate of registration for a specified period not exceeding six months if,

(a) the member refuses to undergo an assessment under subsection (1);

(b) the member refuses to undertake or complete the measure required by the Committee or complete it within the specified time; or

(c) the Committee has been advised that the condition is not likely to be remediable and is of the opinion that the member's condition has exposed or is likely to expose the member's patients to harm or injury. O. Reg. 250/99, s. 2.

(5) No direction shall be given to the Registrar under subsection (4) unless,

(a) the member has been given notice of the Committee's intention to give the direction and of the reasons it believes the direction should be given;

(b) the member has been given a copy of all reports and other documents that have been considered by the Committee in connection with the matter;

(c) the member has been given at least 30 days after receiving the notice and documents under this subsection to make written submissions to the Committee; and

(d) if the member so requests in writing within 30 days after receiving the notice and documents under this subsection, the opportunity to confer with the Committee. O. Reg. 250/99, s. 2.

(6) The Committee may direct the Registrar to remove any of the terms, conditions or limitations imposed on a member's certificate of registration under this section before the end of the specified period if the Committee is satisfied that they are no longer needed. O. Reg. 250/99, s. 2.

(7) The following shall not be used as evidence that the member has committed an act of professional misconduct:

1. Any admission by the member to the Committee or to a person conducting an assessment under subsection (1) of exhibiting behaviour or making remarks of a sexual nature.
2. The results of any assessment undergone by the member under subsection (1) or measures undertaken under subsection (2). O. Reg. 250/99, s. 2.

(8) If terms, conditions or limitations are imposed on a member's certificate of registration under this section, the Committee shall report the matter to the Executive Committee. O. Reg. 250/99, s. 2.

Information

34. (1) At the Committee's request, the Registrar shall forward to the members a request for information from members in order to assist the Committee in carrying out the objects of the quality assurance program. O. Reg. 250/99, s. 2.

(2) Members shall provide the Registrar with accurate information in response to the request within 30 days of receiving it. O. Reg. 250/99, s. 2.

PART X
NOTICE OF MEETINGS AND HEARINGS

35. (1) The Registrar shall ensure that notice is given in accordance with this Part with respect to each of the following that is required to be open to the public under the Act:

1. A meeting of the Council.

2. A hearing of the Discipline Committee respecting allegations of a member's professional misconduct or incompetence. O. Reg. 7/08, s. 1.

(2) The notice must, where possible, be posted not less than 14 days before the date of the meeting or hearing on the website of the College. O. Reg. 7/08, s. 1.

(3) The notice must be published in English and in French. O. Reg. 7/08, s. 1.

(4) The notice must include,

(a) the date, time and location of the meeting or hearing;

(b) a statement of the purpose of the meeting or hearing including, in the case of a hearing, the name of the member against whom the allegations have been made and the member's principal place of practice; and

(c) an address and telephone number at which further information about the meeting or hearing may be obtained. O. Reg. 7/08, s. 1.

(5) The Registrar shall give notice of a meeting or hearing that is open to the public to every person who requests it. O. Reg. 7/08, s. 1.

(6) No meeting or hearing is invalid simply because a person has not complied with a requirement of this Part. O. Reg. 7/08, s. 1.

36. Revoked: O. Reg. 7/08, s. 1.

Optometry Act, 1991

ONTARIO REGULATION 837/93

REGISTRATION

Consolidation Period: From September 14, 2012 to the e-Laws currency date.

Last amendment: O. Reg. 279/12.

This Regulation is made in English only.

Classes of Certificates of Registration

1. The following classes of certificates of registration are prescribed:

1. General certificate of registration.
2. Academic certificate of registration. O. Reg. 837/93, s. 1.

General Certificates of Registration

2. (1) The requirements and qualifications for the issuing of a general certificate of registration to an applicant are:

1. The applicant must have completed an application for a general certificate of registration.
2. The applicant must have one of the following academic qualifications:
    i. A degree in optometry,
        A. awarded by the School of Optometry and Vision Science of the University of Waterloo, or
        B. awarded by an educational institution as a result of the successful completion of a program that has been accredited by the Accreditation Council on Optometric Education or another accrediting body approved by the Council at the time the applicant successfully completed the program, or
    ii. A degree together with any further education or training, or combination of education and training, as specified by a panel of the Registration Committee that when taken together evidences, in the opinion of the panel, completion of a program that is substantially equivalent to a program the completion of which would result in the awarding of the degree referred to in sub-subparagraph i A.

3. The applicant must be able to speak and write in the English or French language with reasonable fluency.

4. Where the applicant has previously practised optometry, there must not be any finding of, or of any current proceeding involving an allegation of, professional misconduct, incompetence or incapacity or any like finding or proceeding against the applicant.

5. The applicant must not have been found guilty in relation to a criminal offence in any jurisdiction. For the purposes of this paragraph, a “criminal offence” includes, without being limited to, an offence under the *Criminal Code*(Canada), the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada).

6. The applicant must have Canadian citizenship, permanent residency or authorization under the *Immigration and Refugee Protection Act* (Canada) to engage in the practice of optometry.

7. The applicant must meet the criteria set out in one of the following subparagraphs:

   i. successful completion, not more than three years before applying for registration, of the standards assessment examinations set or approved by the College,

   ii. successful completion, more than three years before applying for registration, of the standards assessment examinations set or approved by the College and proof, satisfactory to the Registration Committee,

      A. of having provided at least 750 hours of direct optometric care to patients during the 36-month period immediately prior to applying for a general certificate of registration from the College, and of being competent to practise in accordance with the standards of practice on the basis of an assessment by the Registration Committee of any records that the applicant would have been required to maintain pursuant to the regulations, if the applicant had been a member of the College, or

      B. of being competent to practise in accordance with the standards of practice on the basis of an evaluation of the applicant’s knowledge, skills and judgment by the Registration Committee,

   iii., iv Revoked: O. Reg. 279/12, s. 1 (4).

7.1 The applicant has successfully completed an examination in jurisprudence set or approved by the College within the following time period:

i. If the applicant is relying on the requirements described in subparagraph 2 ii in making his or her application, within one year of the applicant satisfying the requirements set out in that paragraph.

ii. In all other cases, within one year after applying for registration.

7.2 If the applicant is required to undergo an assessment or an evaluation by the Registration Committee pursuant to paragraph 7, the applicant must pay in advance the required fee set out in the by-laws of the College.

7.3 Revoked: O. Reg. 224/03, s. 1 (3).

8. The applicant must pay the application, examination and certificate of registration fees. O. Reg. 837/93, s. 2 (1); O. Reg. 249/99, s. 1 (1, 2); O. Reg. 224/03, s. 1 (1-3); O. Reg. 279/12, s. 1 (1-6).

(1.1) If the applicant is relying on the requirements set out in subparagraph 2 ii of subsection (1) in making his or her application for a general certificate of registration, the applicant is required to submit his or her application before he or she commences the education or training, or combination of education and training, referred to in that subparagraph. O. Reg. 279/12, s. 1 (7)

(2) An applicant shall be deemed not to have satisfied the requirements for a certificate of registration if the applicant made a false or misleading statement or representation in his or her application. O. Reg. 837/93, s. 2 (2).

(3) Where an assessment or evaluation is performed by the Registration Committee pursuant to paragraph 7 of subsection (1), the Registration Committee shall provide a report to the Registrar, who shall provide a copy of it to the applicant. O. Reg. 224/03, s. 1 (5); O. Reg. 279/12, s. 1 (8).

(4) Revoked: O. Reg. 224/03, s. 1 (5).

2.1 (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant for a general certificate of registration, the applicant is deemed to have met the requirements of paragraphs 2 and 7 of subsection 2 (1) of this Regulation. O. Reg. 279/12, s. 2.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as an optometrist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 279/12, s. 2.

(3) Without in any way limiting the generality of subsection (2), "good standing" shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding; and

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as an optometrist. O. Reg. 279/12, s. 2.

(4) Where an applicant referred to in subsection (1) is unable to satisfy the Registrar or a panel of the Registration Committee that the applicant practised the profession of optometry to the extent that would be permitted by a general certificate of registration at any time in the three years immediately before the date of that applicant's application, the applicant must meet any further requirement to undertake, obtain or undergo material additional training, experience, examinations or assessments that may be specified by a panel of the Registration Committee. O. Reg. 279/12, s. 2.

(5) An applicant referred to in subsection (1) is deemed to have met the requirements of paragraph 3 of subsection 2 (1) where the requirements for the issuance of the applicant's out-of-province certificate included language proficiency requirements equivalent to those required by that paragraph. O. Reg. 279/12, s. 2.

(6) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the Health Professions Procedural Code. O. Reg. 279/12, s. 2.

3. It is a condition of a general certificate of registration that the member shall provide the College with details of either of the following that relate to the member and that occur or arise after the member is registered:

1. Where the member is or has been registered or licensed to practise optometry in another jurisdiction, a finding of professional misconduct, incompetence or incapacity or any like finding against the member.
2. A finding of guilt in relation to an offence in any jurisdiction. O. Reg. 224/03, s. 2; O. Reg. 279/12, s. 3.

4. A general certificate of registration terminates if the member ceases to be a Canadian citizen or no longer has permanent resident status or authorization under the *Immigration and Refugee Protection Act* (Canada) to engage in the practice of optometry. O. Reg. 837/93, s. 4; O. Reg. 279/12, s. 4.

Academic Certificates of Registration

5. (1) The requirements and qualifications for issuing an academic certificate of registration are:

1. The applicant must have completed an application for an academic certificate of registration.

2. The applicant must hold an appointment as a professor, lecturer, resident, supervising clinician or graduate student at the School of Optometry of the University of Waterloo, or another university or optometric educational facility in Ontario approved by the Council.

3. The applicant must have one of the following academic qualifications:

   i. successful completion of a course in optometry at a university, if the course, at the time the applicant commenced it, was accredited by the Accreditation Council on Optometric Education or another accrediting body approved by the Council, together with the award of a degree of doctor of optometry from that university,

   ii. successful completion of a course in optometry at a university in the United Kingdom, together with the award of a degree from that university, and current or past membership in the British College of Optometrists,

   iii. successful completion of a course outside of Ontario, other than one mentioned in subparagraphs i or ii that the Registration Committee, having considered the rest of the applicant's qualifications, determines is acceptable.

4. The applicant must be able to speak and write in either English or French with reasonable fluency.

5. Where the applicant has previously been registered or licensed as an optometrist in any jurisdiction, or has previously practised optometry, there must not be any finding of, or current proceeding involving an allegation of, professional misconduct, incompetence, incapacity or any like finding or proceeding against the applicant.

6. The applicant must not have been found guilty in relation to a criminal offence in any jurisdiction. For the purposes of this paragraph, a "criminal offence" includes, without being limited to, an offence under the *Criminal Code*(Canada), the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada).

7. The applicant must have Canadian citizenship, permanent residency or authorization under the *Immigration and Refugee Protection Act* (Canada) permitting the applicant to engage in the practice of optometry authorized by the academic certificate.

8. The applicant must successfully complete the jurisprudence examination set or approved by the College at the time of the application.

9. The applicant must pay the applicable fees. O. Reg. 224/03, s. 3; O. Reg. 279/12, s. 6.

(2) An applicant shall be deemed not to have satisfied the requirements for a certificate of registration if the applicant made a false or misleading statement or representation in his or her application. O. Reg. 837/93, s. 5 (2).

5.1 (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant for an academic certificate of registration, the applicant is deemed to have met the requirements of paragraph 3 of subsection 5 (1) of this Regulation. O. Reg. 279/12, s. 7.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as an optometrist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 279/12, s. 7.

(3) Without in any way limiting the generality of subsection (2), “good standing” shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding; and

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as an optometrist. O. Reg. 279/12, s. 7.

(4) Where an applicant referred to in subsection (1) is unable to satisfy the Registrar or a panel of the Registration Committee that the applicant practised the profession of optometry to the extent that would be permitted by an academic certificate of registration at any time in the three years immediately before the date of that applicant’s application, the applicant must meet any further requirement to undertake, obtain or undergo material additional training, experience, examinations or assessments that may be specified by a panel of the Registration Committee. O. Reg. 279/12, s. 7.

(5) An applicant referred to in subsection (1) is deemed to have met the requirements of paragraph 4 of subsection 5 (1) where the requirements for the issuance of the applicant’s out-of-province certificate included language proficiency requirements equivalent to those required by that paragraph. O. Reg. 279/12, s. 7.

(6) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the Health Professions Procedural Code. O. Reg. 279/12, s. 7.

6. An academic certificate of registration is subject to the following terms, conditions and limitations:

1. The certificate is automatically revoked if,

   i. the member ceases to hold an appointment mentioned in paragraph 2 of subsection 5 (1), or

   ii. the member ceases to be a Canadian citizen or permanent resident of Canada or to have authorization under the*Immigration and Refugee Protection Act* (Canada) permitting the member to engage in the practice of optometry as authorized by the academic certificate.

2. The member may engage in the practice of optometry only at the School of Optometry of the University of Waterloo or at another university or optometric educational facility in Ontario approved by the Council, or a facility formally associated with the School of Optometry, university or optometric educational facility, as the case may be.

3. The member must provide the College with details of either of the following that relate to the member and that occur or arise after the member is registered:

   i. where the member is or has previously been registered or licensed as an optometrist in another jurisdiction, a finding of professional misconduct, incompetence, incapacity or any like finding or proceeding against the member, or

   ii. a finding of guilt in relation to an offence in any jurisdiction. O. Reg. 224/03, s. 4; O. Reg. 279/12, s. 8.

6.1 Revoked: O. Reg. 224/03, s. 4.

7. (1) Subject to subsections (2) and (3), it is a condition of a certificate of registration of any class that the member,

(a) provide at least 750 hours of direct optometric care to patients in Canada in every three-year period following the year in which the member is first registered; and

(b) provide an annual report to the Registrar, at a time set by the Registrar, detailing the member's participation in the mandatory continuing education program of the quality assurance program. O. Reg. 224/03, s. 4.

(2) Subject to subsection (3), the Registration Committee may exempt a member holding a certificate of registration of any class who holds an appointment at the School of Optometry of the University of Waterloo or other optometric educational facility in Ontario approved by the Council from the requirement in clause (1) (a) if the member makes a written request to the Registration Committee and satisfies the Registration Committee that the member's academic duties prevented the member from meeting the requirement. O. Reg. 224/03, s. 4.

(3) The Registrar shall refer a member to the Quality Assurance Committee for a practice assessment under the College's quality assurance program,

(a) if a member has failed to meet any of the conditions of a certificate of registration set out in subsection (1) or to meet the published minimum requirements of the mandatory continuing education program of the quality assurance program; or

(b) if the member was granted an exemption under subsection (2) for the three-year period immediately preceding the member's ceasing to hold the appointment mentioned in subsection (2), unless the member can establish to the satisfaction of the Registrar that he or she did provide at least 750 hours of direct optometric care to patients in Canada during that period. O. Reg. 224/03, s. 4.

(4) A member who obtains an exemption pursuant to subsection (2) shall immediately advise the Registrar in writing if the member ceases to hold the appointment mentioned in that subsection. O. Reg. 224/03, s. 4.

8. A member who held an academic certificate of registration on April 26, 1999, shall be issued a general certificate of registration if the following requirements are met:

1. The member files an application for the certificate with the College on or before December 31, 2003.
2. The member satisfies the Registration Committee that on the date of filing the application, the member has held the academic certificate of registration for five or more consecutive years and had provided at least 100 hours of direct optometric care to patients in Canada during each of those years.
3. The member satisfies the Registration Committee that on the date of filing the application the member is a Canadian citizen or permanent resident or is authorized under the *Immigration and Refugee Protection Act* (Canada) to engage in the practice of optometry.
4. The member pays the applicable fees. O. Reg. 224/03, s. 4; O. Reg. 279/12, s. 9.

9. (1) All qualifications or requirements for the issuing of a general certificate of registration are non-exemptible, other than requirements listed in paragraph 3, 4 or 5 of subsection 2 (1). O. Reg. 224/03, s. 4.

(2) All qualifications or requirements for the issuing of an academic certificate of registration are non-exemptible, other than requirements listed in paragraph 4, 5 or 6 of subsection 5 (1). O. Reg. 224/03, s. 4.

10. Revoked: O. Reg. 224/03, s. 4.

11. (1) Subject to subsection (2), the name of the member entered in the register and used on the certificate of registration shall be the same as the name of the member in the documentary evidence of the member's degree in optometry or of a degree that is equivalent to a degree in optometry. O. Reg. 837/93, s. 11 (1).

(2) The Registrar shall issue a certificate of registration using a name other than the name of the member which appears in the documentary evidence referred to in subsection (1) or direct the entry in the register of such a name if,

(a) in the case of an applicant for a first certificate of registration, the applicant deposits with the Registrar the following information,

(i) a certified copy of an order of a court of competent jurisdiction changing the name of the applicant or member,

(ii) a certified copy of a valid certificate of marriage or of a decree absolute of divorce from a court with respect to the applicant or member,

(iii) documentary evidence as to the use of the name requested, or

(iv) any combination of material referred to in subclause (i), (ii) or (iii) and satisfies the Registrar that the use of the name requested is not for any improper purpose; or

(b) in the case of a member to whom a certificate of registration has already been issued, the member,

(i) applies for the change of name to the Registrar,

(ii) returns the member's current certificate of registration, and

(iii) deposits with the Registrar the information described in clause (a). O. Reg. 837/93, s. 11 (2).

12., **13.** Revoked: O. Reg. 57/00, s. 1.

14. (1) At least thirty days before the date the annual fees are payable, the Registrar shall mail to each member a notice requesting,

(a) completion of the annual report;

(b) completion of the continuing education report; and

(c) filing of the certificate of proof of professional liability (malpractice) insurance. O. Reg. 837/93, s. 14 (1).

(2) Upon receipt of the annual report and of the certificate of proof of professional liability (malpractice) insurance, the Registrar shall issue a receipt to the member. O. Reg. 837/93, s. 14 (2).

15. (1) A member whose certificate of registration was suspended by the Registrar may apply for reinstatement if,

(a) the application is made within two years of the date of the suspension; and

(b) the suspension was for,

(i) non-payment of fees,

(ii) failure to complete and return the annual report and continuing education report, or

(iii) failure to provide proof of professional liability insurance. O. Reg. 837/93, s. 15 (1).

(2) The Registrar shall reinstate a member who applies under subsection (1) if the member pays the reinstatement fee set out in the by-laws of the College and,

(a) where the suspension was due in whole or in part to the non-payment of fees, pays those fees as well as any other money owed to the College;

(b) where the suspension was due in whole or in part to a failure to complete and return the annual report or the continuing education report, completes and returns the required reports; or

(c) where the suspension was due in whole or in part to a failure to provide proof of professional liability insurance, provides proof of such insurance. O. Reg. 57/00, s. 2.

(3) Where the Registrar has suspended a member's certificate for any of the reasons mentioned in clause 15 (1) (b) and more than two years have passed since the date of the suspension, the certificate is automatically revoked. O. Reg. 121/94, s. 2.

(4) A member whose certificate of registration was revoked under subsection (3) and who applies to be reinstated must satisfy the requirements for the class of certificate for which reinstatement is sought and pay the application fee and the annual fee payable for the year in which the member wishes to be reinstated. O. Reg. 121/94, s. 2.

16. Omitted (provides for coming into force of provisions of this Regulation). O. Reg. 837/93, s. 16.

College By-laws

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BY-LAWS OF THE COLLEGE OF OPTOMETRISTS OF ONTARIO

PART 1 - DEFINITIONS

1.01 Definitions

(1) In these By-laws, unless otherwise defined or required by the context,

"Act" means the *Optometry Act, 1991* including its associated regulations;

"Appointed Council Member" means a person appointed to Council by the Lieutenant Governor in Council;

"Code" means the *Health Professions Procedural Code*, which is Schedule 2 of the *Regulated Health Professions Act, 1991*;

"College" means the College of Optometrists of Ontario;

"Committee" means a committee established under s. 10 of the Code or a committee established under these By-laws;

"Committee Member" means a member of a Committee;

"Committee Meeting" means a meeting of any Committee but does not include a hearing or a meeting of a panel of a Committee;

"Council" means the Council established under Section 6 of the Act;

"Council Committee Member" means a Member of the College who is elected to Council and appointed by Council to a Committee, and includes a Member appointed to a Committee to fill a vacancy;

"Council Meeting" means a meeting of Council;

"Council Member" means an Elected Council Member, an Appointed Council Member and/or a member of Council selected from the Faculty of the University of Waterloo School of Optometry and Vision Science;

"Elected Council Member" means a Member of the College elected to Council in accordance with these By-laws (including district 6);

“Faculty” means a person who belongs to the faculty of the University of Waterloo School of Optometry and Vision Science. However, Faculty does not include a person who has only been granted an appointment for research or a special appointment, a visiting or adjunct instructor, or a person who holds a similarly restricted position;

"Life Member" means a Member or former Member of the College who has been designated as a Life Member by the College because, among other things, they have practised optometry in Ontario for at least 25 years and have retired from practising optometry;

"Member" means a person or health profession corporation registered with the College, as the case may be;

"Resolution" means a vote of at least a majority of those Council Members in attendance at the meeting and voting on the resolution;

"RHPA" means the *Regulated Health Professions Act, 1991*, including its associated regulations and the Code;

"Special Resolution" means a vote of at least a 2/3^{rds} majority of Council Members in attendance at the meeting and voting on the resolution; and

"Written Resolution" means a Resolution or Special Resolution passed by Council Members in the absence of a meeting in person, and the position or vote of any Council Member may be communicated in writing, including fax, e-mail and any other manner as Council may determine.

(2) Any term not defined in these By-laws shall have the meaning provided to it in the RHPA or the Act.

1.02 Seal

The seal depicted below is the seal of the College.

PART 2 - AMENDMENT OR REVOCATION OF BY-LAWS

2.01 Special Resolution is Required

(1) A Special Resolution is required to amend or revoke these By-laws, or make new By-laws.

(2) Written notice of all motions applying to the making, amending or revoking of a By-law shall be circulated:

(a) to Council Members at least 14 days prior to the tabling of such motion; and

(b) when required under Section 94(2) of the Code, to all Members at least 60 days prior to the tabling of such motion.

(3) Every By-law, including every amendment and revocation of a By-law, shall be dated and numbered according to the date on which it was passed.

PART 3 - BANKING AND FINANCE

3.01 Banking

(1) The College shall open an account at a Schedule 1 Canadian chartered bank.

(2) The College shall:

(a) open all accounts required for the operation of the College, and

(b) unless otherwise earmarked, deposit all monies belonging to the College, with the bank.

(3) Except for payments out of the petty cash fund, all College payments shall be made by electronic transfer, credit card, cheque, draft or money order drawn on the College's bank account.

3.02 Bank Signing Authority

Subject to these By-laws, Council may authorize by Resolution any individual to sign contracts, documents, cheques or other instruments pertaining to the College's bank account. In the absence of such Resolution, any of the President or the Vice-President, in addition to the Registrar, is authorized to sign banking documents on behalf of the College.

3.03 Authorization by Electronic Signature

Electronic signatures may not be used on any securities or negotiable instruments, unless authorized by Council by Resolution.

3.04 Investments

(1) College funds not immediately required for use by the College may be invested.

(2) The Executive Committee shall recommend, for approval by Council, an investment policy for investing the College's funds in a reasonably safe and secure manner.

(3) Council may authorize, by Resolution, any employee of the College to give directions to an investment advisor.

(4) All securities and other negotiable instruments in which the College's monies have been invested shall be registered in the name of the College.

(5) Council shall oversee and ensure that a process is in place to fairly evaluate the College's investments and investment advisor annually.

3.05 Custody of Securities

(1) The Registrar or other individual appointed by Council shall maintain a record of all securities and other negotiable instruments owned by the College.

(2) Any deposit, cashing or transferring of securities shall require the signature of either the President or Vice-President, in addition to the Registrar.

3.06 Borrowing

(1) Council may, by Special Resolution:

(a) borrow money on the credit of the College;

(b) limit or increase the amount of money the College may borrow; or

(c) pledge assets of the College.

The Executive Committee shall review, from time to time, the terms and conditions of any monies borrowed by the College.

3.07 Petty Cash

(1) The College shall maintain a petty cash fund of up to $1,000. The Registrar must authorize expenditures from the petty cash fund.

3.08 Authorization of Expenses

(1) If a College expenditure has previously been approved as an item in the College's budget, or if it is not an item in the College budget but is below $25,000, the expense requires only the Registrar's approval.

(2) If a College expenditure is not an item in the College budget and is above $25,000, the appropriate Council delegated Committee shall review the expenditure and make recommendations to Council as to whether or not to approve the expenditure.

3.09 Fiscal Year

The fiscal year of the College is January 1st to December 31st.

3.10 Auditors

(1) At the first meeting following the election of the Executive Committee, the Executive Committee must appoint an auditor to audit the accounts of the College and hold office for the ensuing year.

(2) Council shall oversee and ensure that a process is in place to fairly evaluate the auditor annually.

(3) The auditor shall present the results of its annual audit to Council when requested to do so by Council. The results of each annual audit shall be published in the annual report of the College.

PART 4 - INSURANCE AND INDEMNIFICATION

4.01 Insurance Coverage for College

The College shall, after consulting with an insurance broker regarding the College's requirements, obtain comprehensive insurance coverage for, among other things, directors and officers liability, fidelity, property damage and personal injury.

4.02 Indemnification of College Representatives

The College shall indemnify and save harmless every Council Member, Committee Member, employee, appointee or other duly designated representative of the College and their heirs, executors and administrators, and estates, out of the funds of the College from and against,

(1) all costs, charges and expenses whatsoever that they sustain or incur in or about any action, suit or proceeding that is brought, commenced or prosecuted against them, for or in respect of any act, deed, matter or thing whatsoever, made done or permitted by them, in or about the execution of the duties of their position or employment, and

(2) all other costs, charges and expenses that they sustain or incur in relation to the College's affairs,

except such costs, charges or expenses incurred as a result of their own willful misconduct or gross negligence.

PART 5 - EXECUTION OF DOCUMENTS

5.01 Signing Authority

(1) Unless otherwise indicated in these By-laws, either the President or Vice-President, in addition to the Registrar, or any individual appointed by Resolution or Special Resolution of Council, may sign documents or instruments requiring the signature of the College.

(2) The Registrar may sign summonses, notices and orders on behalf of the College.

PART 6 - ELECTION OF COUNCIL MEMBERS

6.01 Electoral Districts

(1) Council shall consist of:

(a) Nine Elected Council Members elected from the following electoral districts:

(i) **"District 1"** which comprises the municipality of Toronto and the regional municipalities of Halton, City of Hamilton, Niagara, Peel and York;

(ii) **"District 2**" which comprises the Northern Electoral District, composed of the territorial districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Rainy River, City of Greater Sudbury, Thunder Bay and Timiskaming, the counties of Bruce, Dufferin, Grey, Haliburton, Huron; Renfrew and Simcoe and the district municipality of Muskoka;

(iii) **"District 3"** which comprises the Eastern Electoral District, composed of the counties of Frontenac, Hastings, Lanark, Northumberland, Peterborough, Prince Edward, Kawartha Lakes, Leeds & Grenville, Lennox and Addington, Prescott and Russell United Counties, Stormont, Dundas and Glengarry and the Durham Region and the City of Ottawa;

(iv) **"District 4"** which comprises the Western Electoral District, composed of Brant, Elgin, Essex, Chatham-Kent, Lambton, Middlesex, Oxford, Perth and Wellington and the regional municipalities of Haldimand County, Norfolk County and Waterloo; and

(v) **"District 5"** which comprises the Provincial Electoral District, composed of the whole of the Province of Ontario;

(b) 8 Appointed Council Members; and

(c) 1 Member, who has been selected from the Faculty of the University of Waterloo School of Optometry and Vision Science, provided that that person has first been elected, in the manner set out in these By-laws, by those Members who belong to the Faculty of the University of Waterloo School of Optometry and Vision Science. The electoral district for this Council position will be referred to as "**District 6**".

(2) The following electoral districts shall elect the following number of Elected Council Members:

District	Elected Council Members
District 1	2
District 2	1
District 3	1
District 4	1
District 5	4
District 6	1

(3) With the exception of district 6:

(a) Council may, by Special Resolution, redefine:

(i) the geographic area of each electoral district; and

(ii) the number of Elected Council Members for each electoral district,

to create balanced representation amongst the electoral districts based on general population; and

(b) if an electoral district has no candidate at the time of an election, that Council seat shall be transferred to District 5 to allow for any eligible Member to stand for election for that Council seat.

6.02 Voting Eligibility

A Member is eligible to vote in an election for Council if, on the 45th day before the election, the Member:

(a) is the holder of:

(i) a general certificate of registration; or

(ii) an academic certificate of registration; and

(b) after having been provided with an opportunity to rectify any failure of their obligations to the College:

(i) have paid any fee, penalty or order for costs owing to the College;

(ii) have submitted to the College all required forms and documents; and

(iii) is otherwise in good standing with the College;

6.03 Timing of Council Member Elections/Selection

(1) Elections or selection for Council shall take place as follows:

(a) For district 1:

(i) one Council Member in 2021 and every third year thereafter; and

(ii) one Council Member in 2022 and every third year thereafter;

(b) For districts 2 and 3 one Council Member each in 2022, and every third year thereafter;

(c) For district 4 one Council Member in 2021, and every third year thereafter;

(d) For district 5:

(i) one Council Member in 2020 and every third year thereafter;

(ii) one Council Member in 2021 and every third year thereafter; and

(iii) two Council Members in 2022 and every third year thereafter;

(e) For district 6, one Council Member in 2021 and every third year thereafter.

(2) Council elections and selection shall take place before November 1st in any given year.

6.04 Eligibility for Election of Council Members for Districts 1 Through 5

(1) A Member shall be eligible for election to Council if:

(a) by the deadline for the receipt of the nomination:

(i) the Member principally resides in or practises optometry in the district for which the Member is seeking election;

(ii) the Member is the holder of:

(A) a general certificate of registration; or

(B) an academic certificate of registration,

and the certificate is not subject to a term, condition or limitation that does not already apply to every Member who possesses that class of certificate;

(iii) the Member is not a member of the Faculty of the University of Waterloo School of Optometry and Vision Science;

(iv) the Member files with the Registrar a written agreement to resign from all of the applicable following positions if elected as a Council Member:

(A) an elected representative, director or officer or employee of, or a party to a contractual relationship (if it is reasonable to expect that a real or apparent conflict of interest may arise) to provide services to, the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council, or

(B) an appointed Committee chairperson or member of a committee of the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council;

(b) after having been provided with an opportunity to rectify any failure in their obligations to the College, the Member:

(i) haves paid any fee, charge or order for costs owing to the College,

(ii) haves submitted to the College all required forms and documents, and

(iii) is otherwise in good standing with the College;

(c) the Member is not the subject of any disciplinary or incapacity proceedings; and

(d) the Member has not been disqualified by Council as a Council Member or Committee Member in the preceding six years; and

(2) No Member shall be a candidate for Council Member in more than one district during an election.

6.05 Eligibility for Selection of District 6 Council Member

(1) A Member who is a member of the Faculty of the University of Waterloo School of Optometry and Vision Science shall be eligible for selection to Council if, on the date of selection:

(a) the Member files with the Registrar a written agreement to resign from all of the applicable following positions if selected as a Council Member:

(i) an elected representative, director or officer or employee of, or a party to a contractual relationship (if it is reasonable to expect that a real or apparent conflict of interest may arise) to provide services to, the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council, or

(ii) an appointed Committee chairperson or member of a committee of the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council;

(b) the Member is the holder of:

(i) a general certificate of registration; or

(ii) an academic certificate of registration;

and the certificate is not subject to a term, condition or limitation that does not already apply to every Member who possesses that class of certificate;

(c) after having been provided with an opportunity to rectify any failure in their obligations to the College, the Member:

(i) has paid any fee, charge or order for costs owing to the College,

(ii) has submitted to the College all required forms and documents, and

(iii) is otherwise in good standing with the College;

(d) the Member is not the subject of any disciplinary or incapacity proceedings;

(e) the Member has not been disqualified by Council from being a Council Member or Committee Member in the preceding six years.

(2) No Member shall be a candidate for Council Member in more than one district during an election.

6.06 Term of Office for Council Members

(1) The term of office of a Council Member is three years, beginning from the first regular Council meeting after the Member was elected, appointed or selected, as the case may be, until their successor takes office in accordance with these By-laws.

(2) A Council Member may serve more than one term. However, no person may be an Elected Council Member for more than nine consecutive years.

6.07 Nominating Procedure

(1) At least 60 days before the date of election each year, the Registrar shall, in the districts where elections are to be held in that year, invite in writing any Member wishing to stand for election to Council.

(2) A Member's written intent must be returned to the Registrar no later than 30 days before the election.

6.08 Election Procedure

(1) Each eligible Member may vote once for a candidate:

(a) in one of the following:

(i) in the district in which the Member's primary place of practice is located; or, if a Member does not practise optometry in Ontario, in the district where they primarily reside; or

(ii) if the Member also belongs to the Faculty of the University of Waterloo School of Optometry and Vision Science, in district 6; and

(b) in district 5.

(2) If a Member practises optometry in multiple electoral districts and has not declared a primary place of practise, the College shall select the electoral district in which the Member is eligible to vote on the Member's behalf.

When there is more than one candidate for a position, the Registrar shall, at least 15 days before an election, send each Member entitled to vote in an election the ballot, voting instructions and the campaign material provided by each candidate.

(3) At the completion of the election, the Registrar shall tally the votes on each ballot received.

(4) The candidate (or their designate) is entitled to be present while the Registrar tallies the votes.

(5) The candidate who receives the most votes cast on a ballot for each contested electoral district shall be declared elected.

(6) If the votes on a ballot result in a tie, the Registrar shall resolve the deadlock by lot.

(7) If a position in an electoral district is not contested, the Registrar shall declare the candidate elected by acclamation.

(8) Where an issue arises with respect to a ballot that is not governed by these By-laws, the Registrar shall resolve the dispute in a fair and democratic manner.

(9) The Registrar shall report the results of the election to Council and the Members.

(10) If Council determines, by Special Resolution, that an alternative method of voting would be preferable, Council shall create a procedure for voting in accordance with generally accepted principles of democracy and fairness.

6.09 Vote Recount

(1) If a candidate has lost the election, the candidate (or their designate) may request a recount in the electoral district in which they were a candidate, provided that:

(a) they have lost the election by no more than 20 votes; and

(b) the request is made in writing to the Registrar within 7 days of the results of the election being reported.

(2) The recount shall occur within 14 days of a valid recount request.

(3) The candidate requesting the recount and the candidate previously declared the winner (or a designate of each) shall be entitled to be present at the recount.

(4) If the outcome of the recount changes the election results:

(a) the candidate requesting the recount shall be refunded any fees paid; and

(b) the candidate who has now received the most votes on the ballot shall be declared elected.

(5) If the recount of the votes on the ballot results in a tie, the Registrar shall resolve the deadlock by lot.

(6) Where an issue arises with respect to the recount that is not governed by these By-laws, the Registrar shall resolve the dispute in a fair and democratic manner.

(7) The Registrar shall report the results of the recount to Council and the Members.

(8) The Registrar may destroy the ballots 8 days after the election or, if a recount has been requested, 8 days after the recount.

6.10 Election Challenge

(1) A candidate or their designate may only challenge an election if:

(a) they submit the challenge in writing to the Registrar within:

(i) 7 days after the election results are reported; or

(ii) if a vote recount has occurred, 7 days after the vote recount results are reported; and

(b) provide a detailed description of the reason for challenging the vote.

(2) Within 7 days of the Registrar receiving a valid election challenge, Council shall appoint:

(a) a panel consisting of 3 Council Members, at least one of whom is an Appointed Council Member, to hold an inquiry into the election (the "Election Challenge Committee"); and

(b) provide a deadline (which may, depending on the circumstances, be extended) by which the Election Challenge Committee must report its findings to Council in writing.

(3) No member of the Election Challenge Committee shall be a Council Member who was elected during the election being disputed.

(4) The Election Challenge Committee shall:

(a) provide all candidates with:

(i) notice of the challenge in writing; and

(ii) a reasonable opportunity to make submissions regarding the challenge in the time and manner determined by the Election Challenge Committee.

(b) conduct an investigation, if necessary; and

(c) based on a majority vote, make findings of the facts; and

(d) report its findings and reasoning to the candidates and to Council in writing.

(5) Depending on the findings of the Election Challenge Committee, Council may, by Resolution, direct the Registrar to:

(a) hold a new election for some or all of the districts;

(b) recount the votes;

(c) hold a by-election or run-off between two candidates;

(d) carry out any other means that Council determines would resolve the challenge in a fair and democratic manner.

(6) If any allegation of the challenge is determined by the Election Challenge Committee to be valid, the candidate challenging the election shall be refunded any fees paid to the College for making the challenge.

6.11 Council Vacancies

(1) If an Elected Council Member's seat becomes vacant during the first 2 years of a Council Member's term:

(a) Council shall appoint the candidate who received the most votes during the previous election to fill the vacant position in that district provided that:

(i) the Member agrees to fill the vacant position; and

(ii) the Member is eligible to be a Council Member; or

(b) if the above requirements cannot be satisfied, the Registrar shall hold a by-election to fill the vacancy.

(2) If the seat of an Elected Council Member becomes vacant in the third year of a Council Member's term, Council is not required to fill the vacancy.

(3) If a vacancy on Council is filled by holding a by-election and the votes cast result in a tie, the Registrar shall resolve the deadlock by lot.

(4) Where an issue arises that is not governed by these By-laws during an election, the Registrar shall resolve the dispute in a fair and democratic manner.

(5) The term of the replacement Council Member shall continue until the term of the previous Elected Council Member's term would have expired.

6.12 Unexpected Circumstances

If, for whatever reason, the election cannot be held in the time or manner intended, the Registrar with consent of the Executive Committee, may delay or extend the election so as to hold the election in a fair and democratic manner.

PART 7 - ELECTION OF OFFICERS

7.01 Officers

The officers of the College consist of a President and Vice-President as well as such other officer position as Council may determine by Special Resolution.

7.02 Nomination Procedure

(1) Before the first regular Council Meeting each year, the Registrar shall invite in writing all Council Members wishing to stand for election to the office of the President, Vice-President and any other officer position as Council may determine.

(2) A Council Member's written intent must be returned to the Registrar before the Council Meeting when the election of officers is to take place.

7.03 Process for Election of Officers

(1) The election of officers shall take place on an annual basis at the first Council Meeting of each year.

(2) At a Council Meeting during which an election of officers occurs:

(a) a special quorum of at least 2/3rds of all Council Members must be present;

(b) the Registrar shall present the names of candidates who have indicated their interest for each officer's position;

(c) when an officer's position is not contested, the Registrar shall declare the candidate elected by acclamation; and

(d) when there is more than one candidate for an officer's position:

(i) voting shall be conducted by secret ballot;

(ii) the Registrar shall count the ballots, and report the results to Council;

(iii) the candidate who receives the most votes cast on a ballot shall be declared elected; and

(iv) if there is a tie in votes cast, the Registrar shall resolve the deadlock by lot.

(3) Where an issue arises that is not governed by these By-laws during an election, the Registrar shall resolve the dispute in a fair and democratic manner.

7.04 Officer Term Limits

The term of an officer is one year, beginning from the first regular Council meeting after the officer was elected by Council until the officer's successor takes office.

7.05 Officer Vacancies

(1) If the position of the President becomes vacant, the Vice-President shall become President.

(2) If the position of the Vice-President becomes vacant, Council shall elect by Resolution a Council Member to fill the position(s) for the remainder of the term.

(3) If the position of any other officer becomes vacant, that position:

(a) may remain vacant until the term of the previous holder of that position would have expired; or

(b) Council may, by Resolution, elect a Council Member to fill the position for the remainder of the term.

(4) If there is a tie in votes cast for an election for a vacant officer's position, the Registrar shall resolve the deadlock by lot.

(5) Where an issue arises that is not governed by these By-laws during an election, the Registrar shall resolve the dispute in a fair and democratic manner.

PART 8 - APPOINTMENT TO COMMITTEES

8.01 Eligibility of Members for Appointment to Committees

A Member shall be eligible to be appointed for a term of one year as a Committee Member if, on the date of appointment:

(1) the Member's certificate of registration is not subject to a term, condition or limitation that does not already apply to every Member who possesses that class of certificate;

(2) the Member is not the subject of any disciplinary or incapacity proceeding;

(3) the Member is not:

(a) an elected representative, director or officer or employee of, or a party to a contractual relationship (if it is reasonable to expect that a real or apparent conflict of interest may arise) to provide services to, the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council, or

(b) an appointed Committee chairperson or member of a committee of the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council if it is reasonable to expect that a real or apparent conflict of interest may arise;

(4) the Member has not been disqualified as Council Member or Committee Member in the preceding three years; and

(5) after having been provided with an opportunity to rectify any failure in their obligations to the College, the Member:

(a) has paid any fee, charge or order for costs owing to the College,

(b) has submitted to the College all required forms and documents, and

(c) is otherwise in good standing with the College.

8.02 Obtaining Volunteers for Committees

(1) In the case of Council Members:

(a) before the first regular meeting of Council in each year the Registrar shall invite in writing all Council Members to indicate in writing their preferences for committee appointment(s); and

(b) a Council Member's written intent must be returned to the Registrar before the first regular meeting of the Council for the year.

(2) In the case of non-Council Members:

(a) the Registrar, at the same time that nomination ballots for Council are distributed, shall invite in writing all Members to indicate in writing any Committee on which they volunteer to sit; and

(b) a Member's written intent must be returned to the Registrar before the first regular meeting of Council for the year.

(3) A Member who volunteers to serve on a Committee and is either:

(a) an elected representative, director or officer or employee of, or a party to a contractual relationship (if it is reasonable to expect that a real or apparent conflict of interest may arise) to provide services to, the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council, or

(b) an appointed Committee chairperson or member of a committee of the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council if it is reasonable to expect that a real or apparent conflict of interest may arise;

must, at the time of submitting their written intent, file with the Registrar a written agreement to resign from the conflicting position if appointed to serve on a Committee.

8.03 Process for Appointing Committee Members and Committee Chairs

(1) As soon as possible after the Executive Committee's election, the Council, shall appoint Council Members and non-Council Members volunteering to sit on a Committee and shall:

(a) review the Committee preferences provided to the Registrar by each Council Member and non-Council Member;

(b) consider other relevant factors including past experience, conflicts of interest, workload and the fair representation of each district on Committees;

(c) rank Council Members and non-Council Members in order of preference, and include documentation of each person's qualifications relating to the work of the Committee; and

(d) shall appoint a chair for each Committee.

(2) If the Council is unable to meet the composition requirements set out in these By-laws of any Committee, Council may temporarily adjust the composition until those requirements can be met.

8.04 Committee Vacancies

(1) If a vacancy of a Committee Member occurs, the Executive Committee may appoint a replacement Committee Member.

(2) If a vacancy of a Committee Chair occurs, the Executive Committee must appoint a replacement Committee Chair.

(3) At the next Council meeting, the Executive Committee shall present the replacement Committee Member(s) or replacement Committee Chair(s) to Council to be ratified by Resolution.

PART 9 - DISQUALIFYING OR SANCTIONING COUNCIL MEMBERS AND COMMITTEE MEMBERS

9.01 Grounds for Disqualifying or Sanctioning an Elected Council Member or Committee Member

(1) Council shall disqualify an Elected Council Member or Committee Member from sitting on Council or a Committee, as the case may be, if they:

(a) are found by a panel of the Discipline Committee to be incompetent or to have committed an act of professional misconduct;

(b) are found by a panel of the Fitness to Practise Committee to be an incapacitated member;

(c) were elected in electoral districts 1 through 4, and cease to principally reside in or practise optometry in the electoral district for which the Member was elected;

(d) were elected in district 6 and cease to be a member of the Faculty of the University of Waterloo School of Optometry and Vision Science;

(e) cease to be the holder of:

(i) a general certificate of registration; or

(ii) academic certificate of registration;

(f) after having been provided with an opportunity to rectify any failure in their obligations to the College:

(i) remain in default of any fee, charge or order for costs owing to the College,

(ii) fail to submit to the College all required forms and documents, or

(iii) cease to otherwise be in good standing with the College;

(g) have a term, condition or limitation on their certificate of registration that does not already apply to every Member who possesses that class of certificate;

(h) fail to sign, on an annual basis, a confidentiality agreement with the College, in the form approved by Council;

(i) breach Section 36 of the RHPA or the By-laws of the College that require Council Members or Committee Members to preserve the confidentiality of information disclosed during the course of their duties as a Council Member or Committee Member;

(j) depending on the eligibility requirements for a Council Member or Committee Member set out in Parts 6 and 8, become an elected representative, board member, director, officer or employee of, or enter into a contractual relationship to provide services (if it is reasonable to expect that a real or apparent conflict of interest may arise) to:

(i) the Ontario Association of Optometrists,

(ii) the Canadian Association of Optometrists, or

(iii) any other organization determined by Council;

(k) depending on the eligibility requirements for a Council Member or Committee Member set out Parts 6 and 8, become an appointed committee chairperson or member of a committee of:

(i) the Ontario Association of Optometrists,

(ii) the Canadian Association of Optometrists, or

(iii) any other organization determined by Council;

(l) subject to the discretion of Council to excuse the absence:

(i) fail to attend any two of three consecutive regular meetings of the Council;

(ii) fail to attend any two of three consecutive regular meetings of a Committee of which they are a member; and

(iii) fail to attend a hearing or proceeding, or part thereof, of a panel on which they sit.

(2) An Elected Council Member or a Committee Member may also be removed from their position or sanctioned if they contravene their duties (including abiding by the College's Code of Conduct and conflict of interest provisions).

9.02 Grounds for Requesting the Disqualification or Sanctioning of an Appointed Council Member

(1) The College shall request the Public Appointments Secretariat to disqualify and remove an Appointed Council Member from Council if the Appointed Council Member:

(a) becomes a Member;

(b) fails to sign, on an annual basis, a confidentiality agreement with the College, in the form approved by Council;

(c) breaches Section 36 of the RHPA or the By-laws of the College that require Committee Members to preserve the confidentiality of information obtained in the course of their duties as a Committee Member;

(d) depending on whether the person is a Council Member or Committee Member, becomes an elected representative, Board member, director, officer or employee of, or enters into a contractual relationship (if it is reasonable to expect that a real or apparent conflict of interest may arise) to provide services to the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council;

(e) depending on whether the person is a Council Member or Committee Member, becomes an appointed Committee chairperson or member of a Committee of the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council; or

(f) subject to the discretion of Council to excuse the absence:

(i) fails to attend any two of three consecutive regular meetings of the Council;

(ii) fails to attend any two of three consecutive regular meetings of a Committee of which they are a Member; or

(iii) fails to attend a hearing or proceeding, or part thereof, of a panel on which they sit.

(2) The College may also request the removal of an Appointed Council Member or sanction an Appointed Council Member if they contravene their duties (including abiding by the College's Code of Conduct and conflict of interest provisions).

9.03 Process for Disqualifying or Sanctioning a Council Member and Committee Member

(1) The following process shall be used to disqualify or sanction an Elected Council Member, Committee Member or Appointed Council Member (the "Subject Member"):

(a) Where a Council Member or the Registrar believes that the College should consider the disqualification or sanction of the Subject Member, the Council Member or Registrar shall advise the Executive Committee in writing;

(b) The Executive Committee shall:

(i) provide the Subject Member with:

(A) notice of the concerns in writing, and

(B) reasonable time to make submission in the time and manner determined by the Executive Committee;

(c) The Executive Committee shall, based on at least a 2/3^{rds} majority vote, make a preliminary finding of the facts and, in writing, report those findings and its reasoning to the Subject Member and Council, and, depending on the circumstances, the individual who brought the matter to the Executive Committee's attention;

(d) The Executive Committee may then, based on at least a 2/3rds majority vote, either:

(i) sanction the Subject Member, provided the sanction does not include the disqualification, request to disqualify or dismissal of the Subject Member. Sanctions by the Executive Committee may include:

(ii) dismiss the allegations against the Subject Member; or

(iii) refer the matter to Council.

(e) If either the individual who brought the matter to the Executive Committee's attention or the Subject Member is of the view that Council's involvement is required, they shall provide, in writing, their concern to the attention of the President within 15 days after being notified and the issue will be placed on the agenda for the next Council meeting.

(f) Council shall:

(i) advise the Subject Member and the individual who brought the matter to the Executive Committee's attention:

(A) that the matter has been referred to Council; and

(B) of their opportunity to make submissions in the manner determined by Council;

(ii) conduct an investigation, if necessary; and

(iii) by Special Resolution make a finding of fact and, in writing, report those findings and its reasoning to the Subject Member, and, depending on the circumstances, the individual who brought the matter to the Executive Committee's attention;

(g) Council may then, based on a Special Resolution, either:

(i) sanction the Subject Member (which may include the disqualification, or the request to disqualify the Subject Member); or

(ii) dismiss the allegations against the Subject Member.

(2) In determining the appropriate sanction, the Executive Committee and Council should be guided by the principle that the primary purpose of sanctions is to protect the College and to modify behaviour that could be potentially harmful to College.

(3) The Subject Member, throughout the process, shall be temporarily suspended as a Council Member or Committee Member until a final decision by the College has been rendered or the Public Appointments Secretariat has removed the Appointed Council Member, as the case may be.

(4) Before any debate is had or vote is taken by Council, throughout the process, Council shall consider whether the public should be excluded from all or part of the meeting in accordance with the Code.

(5) Where Council votes to request the Public Appointments Secretariat to disqualify and remove an Appointed Council Member, the College shall make such a request to the Public Appointments Secretariat.

(6) If the Subject Member is disqualified or removed as a Council Member or Committee Member, the College shall act as if a vacancy had been created as a result of a resignation.

(7) A Subject Member who has been disqualified ceases to be a Council Member and a member of all Committees.

9.04 Temporary Suspension of a Council Member or Committee Member

(1) A Council Member or Committee Member who becomes the subject of a disciplinary or incapacity proceeding (including, in the case of an Elected Council Member, one which originates at any time after the deadline for receipt of nominations), shall not serve on Council or on any Committee until a final decision (including any appeal) has been rendered.

(2) An Elected Council Member and/or a Committee Member who, after having been provided with an opportunity to rectify a failure in their obligations to the College:

(a) remains in default of any fee, charge or order for costs owing to the College,

(b) fails to submit to the College all required forms and documents, or

(c) ceases to otherwise be in good standing with the College;

(including, in the case of an Elected Council Member, a default which originates at any time after the deadline for receipt of nominations), shall not serve on Council or any Committee until the failure is remedied or the Elected Council Member and/or a Committee Member is disqualified.

PART 10 - DESCRIPTION OF DUTIES

10.01 Officers on Executive Committee

(1) The President and Vice-President are members of the Executive Committee.

(2) In addition to the President and Vice-President, Council may, by Special Resolution, determine the composition of the Executive Committee provided that all members of the Executive Committee are Council Members.

(3) Each additional member of the Executive Committee shall be elected in the same manner as the officers.

10.02 President

(1) The President, with Council, is responsible for fulfilling mandate, objectives and strategic plans of the College. The President is directly accountable to Council and indirectly accountable to the government, the public and the profession for the effective governance of the College.

(2) The President's duties include:

(a) providing effective leadership for Council;

(b) presiding as chair of all Council Meetings and Executive Committee meetings, unless another chair has been appointed;

(c) overseeing the operations of Council, including approving the agenda for Council Meetings and presenting an Executive Committee report at each Council Meeting;

(d) working with the Registrar to ensure the efficient conduct of all Council Meetings and Executive Council meetings and that decisions of Council and the Executive Committee are implemented;

(e) participating in the orientation of new Council Members, officers, Committee Members, chairs and volunteers and encouraging Members to participate in Council;

(f) overseeing and ensuring that a process is in place to fairly evaluate the Registrar;

(g) along with the Registrar, representing the College as the authorized spokesperson on College policies and positions;

(h) signing contracts, documents or instruments on behalf of the College;

(i) liaising with the Registrar on any issue relating to the interaction between Council Members and College staff; and

(j) any other duty determined by Council.

10.03 Vice-President

(1) In the absence, inability or refusal of the President to act, the Vice- President shall have all the powers and perform all the duties of the President.

(2) The Vice-President is directly accountable to Council and indirectly accountable to the government, the public and the profession for the effective governance of the College.

(3) The Vice-President's duties include:

(a) serving on the Executive Committee;

(b) any duty delegated by the President;

(c) signing contracts, documents or instruments on behalf of the College; and

(d) any other duty determined by Council.

10.04 Registrar and CEO

(1) The Registrar holds the most senior position on the College's staff and is the chief executive officer of the College.

(2) The Registrar is directly accountable to Council and, between Council meetings, to the Executive Committee.

(3) The Registrar's duties include:

(a) overseeing the day to day affairs of the College;

(b) ensuring compliance with statutory obligations;

(c) implementing and monitoring College policies;

(d) facilitating the orderly transfer of presidential responsibility, when required;

(e) preparing and maintaining minutes of all Council and Executive Committee meetings and maintaining the College's records, documents and register;

(f) preparing agendas for meetings of Council and the Executive Committee, and submitting those agendas to the President for approval;

(g) providing notice of all Council and Executive Committee meetings;

(h) establishing and maintaining administrative, human resource, and financial operations of the College's office, in collaboration with Council and the Executive Committee, to ensure effective management of the College;

(i) hiring, promoting, terminating and establishing the terms, duration and severances of employment of College staff;

(j) signing contracts, documents and other instruments as may be assigned by Council or as are incidental to the office of the Registrar;

(k) recruiting personnel, ensuring an annual performance assessment and, when applicable, encouraging continuing professional development for College staff';

(l) acting as official spokesperson for the College; and

(m) any other duty determined by Council.

10.05 Council Members

(1) The primary functions of a Council Member:

(a) is to debate and establish College policy; and

(b) to serve as a liaison between the College and those who elect or appoint them.

(2) Council Member duties include:

(a) working with Council to abide by, develop, enforce and propose amendments to:

(i) the RHPA;

(ii) the Act; and

(iii) these By-laws;

(b) establishing policy, strategic direction and goals of the College, including approving statements of principles and positions related to College policy;

(c) supporting and implementing Council decisions;

(d) preparing for each Council meeting;

(e) monitoring the performance of the Registrar through feedback reports prepared by the President;

(f) ensuring appropriate succession planning for the Registrar; and

(g) any other duty determined by Council.

10.06 Committee Chairs

(1) The Committee chair reports to Council.

(2) Committee chair duties include:

(a) chairing Committee meetings;

(b) approving meeting agendas prepared by College staff;

(c) assessing whether Committee Members have the resources and training to effectively perform the Committee's work;

(d) ensuring that the activities of the Committee are conducted within budget;

(e) working with the Committee and College staff to establish, monitor and execute Committee goals;

(f) providing effective leadership for the Committee and facilitating Committee Meetings;

(g) liaising with Council and reporting to the Executive Committee the affairs of the Committee;

(h) being spokesperson for the Committee and ensuring all Committee Members publicly support Committee decisions; and

(i) any other duty determined by Council.

PART 11 - OBLIGATIONS OF COUNCIL AND COMMITTEE MEMBERS

11.01 Conflict of Interest

(1) Council Members and Committee Members must not engage in any activities or decision-making where a conflict of interest may arise.

(2) A conflict of interest means a Council Member or Committee Member's personal or financial interest or participation in an arrangement or agreement which influences, is likely to influence, or could be perceived as influencing that person's judgment or decision-making with respect to College matters.

(3) The personal or financial interests of any family member or a close relation (such as a friend or business associate) of a Council Member or Committee Member shall be interpreted to be the interests of a Council Member or Committee Member.

(4) Council Members and Committee Members must recognize that even the appearance of a conflict of interest can bring discredit to the College, and should be dealt with in the same manner as an actual conflict of interest.

(5) A conflict of interest may amount to a breach of Council Members' fiduciary obligations and can create liability for everyone involved.

(6) A Council Member or Committee Member shall not use College property or information of any kind to advance their own interests.

11.02 Process for Declaring a Conflict of Interest for Council Members

(1) If a Council Member believes or suspects that he, she or any other Council Member may have a conflict of interest, including an appearance of a conflict of interest, in any matter which is the subject of deliberation or action by Council, they shall, prior to any consideration of the matter at the meeting, declare it to Council.

(2) If there is any doubt about whether a conflict of interest exists, any Council Member may introduce a motion to have the conflict of interest issue determined by Council. On such a motion:

(a) the chair presiding over Council shall provide the Council Member introducing the motion a brief opportunity to explain why they believe the Council Member may have a conflict of interest;

(b) the chair presiding over Council shall provide the Council Member who is the subject of the potential conflict of interest a brief opportunity to explain why they believe that they do not have a conflict of interest;

(c) Council shall determine by Special Resolution using a secret ballot whether the Council Member has a conflict of interest; and

(d) The Council Member who is the subject of the potential conflict of interest and the Council member who initiates the conflict of interest motion shall not participate in the vote.

(3) If a Council Member has or is determined to have a conflict of interest with respect to a matter that is the subject of deliberation or action by Council:

(a) the conflict of interest shall be recorded in the minutes of the Council meeting; and

(b) the Council Member shall:

(i) not participate in the debate in respect of the matter;

(ii) refrain from voting on the matter;

(iii) absent himself or herself from the room; and

(iv) not attempt in any way to influence the voting or do anything that might be perceived as attempting to influence the decision of Council on the matter.

11.03 Process for Declaring a Conflict of Interest for Committee Members

(1) If a Committee Member believes or suspects that they or any other Committee Member may have a conflict of interest, including an appearance of a conflict of interest, in any matter which is the subject of deliberation or action by a Committee, they shall:

(a) prior to any consideration of the matter at the meeting, disclose to the Committee chair, Committee staff support, Committee, Registrar and/or the College's legal counsel the fact that they or any other Committee Member may have a conflict of interest;

(b) if the Committee Member has a conflict of interest or if there is any doubt about whether a conflict of interest exists, the Committee Member shall, unless the Committee chair has agreed otherwise:

(i) not participate in the debate in respect of the matter;

(ii) refrain from voting on the matter;

(iii) absent themself from the room; and

(iv) not attempt in any way to influence the voting or do anything that might be perceived as attempting to influence the decision of the Committee on the matter; and

(c) the conflict of interest shall be recorded in the minutes of the Committee meeting.

11.04 One-Year Waiting Period

(1) Subject to subsection 11.04(2), there shall be a one-year waiting period with respect to:

(a) a Council Member or Committee Member who wants to work as an employee or on a contract with the College (if it is reasonable to expect that a real or apparent conflict of interest may arise) or hold any appointment by the College;

(b) an employee, contractor or any other appointee of the College who wants to be a Council Member or Committee Member; and

(c) an employee, contractor, appointee, director or officer of the Ontario Association of Optometrists, the Canadian Association of Optometrists or any other organization determined by Council who wants to:

(i) be an employee or work on a contract with the College (if it is reasonable to expect that a real or apparent conflict of interest may arise); or

(ii) hold any appointment by the College.

The one-year waiting period shall commence on the first day following the last day that the conflicting position was held by the individual.

(2) Council may, under exceptional circumstances, adjust the one-year waiting period by Special Resolution.

11.05 Confidentiality

(1) Section 36(1) of the RHPA states, in part:

> Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every Member of a Council or committee of a College shall keep confidential all information that comes to their knowledge in the course of their duties and shall not communicate any information to any other person ….

(2) Council Members and Committee Members, College staff and persons retained or appointed by the College shall:

(a) maintain confidentiality of information disclosed to them in the course of discharging their duties, unless otherwise authorized by Council or permitted under Section 36(1) of the RHPA;

(b) refrain from communicating to Members, including Council Members or Committee Members, information regarding registration, complaints, reports, investigations, disciplinary or fitness to practise proceedings which could be perceived as an attempt to influence a statutory decision or a breach of confidentiality, unless:

(i) they are a Member of the same panel considering the matter, or

(ii) when there is no panel, of the same Committee considering the matter.

However, Council Members and Committee Members may discuss any other matter not prohibited by Section 36(1) of the RHPA and not arising from an *in camera* meeting;

(c) be aware of and understand those exceptions to confidentiality obligations in Section 36(1) of the RHPA; and

(d) seek advice if any doubt whether an exception applies.

11.06 Code of Conduct

(1) Council Members and Committee Members must, at all times, when discharging their College duties, act in the College's best interest, maintain high standards of integrity, honesty, and loyalty.

(2) The College's Code of Conduct for Council Members and Committee Members includes:

(a) being familiar and comply with the provisions of the RHPA, the Act, and the By-laws and policies of the College;

(b) actively participating in Council and Committees;

(c) regularly attending and being prepared for meetings on time, and participating constructively in debates;

(d) participating in all deliberations in a respectful and courteous manner, recognizing the diverse background, skills and experience of Council Members and Committee Members;

(e) abiding by and endorsing Council and Committee decisions, regardless of the level of prior personal disagreement; and

(f) avoiding and, where that is not possible, declaring any appearance of or actual conflicts of interest.

(g) preserving confidentiality of all information before Council and/or its Committees unless disclosure has been authorized by Council or otherwise exempted under s. 36(1) of the RHPA;

(h) refraining from communicating to Members, including Council Members or Committee Members, information regarding registration, complaints, reports, investigations, disciplinary or fitness to practise proceedings which could be perceived as an attempt to influence a statutory decision or a breach of confidentiality, unless:

(i) they are a Member of the same panel considering the matter, or

(ii) when there is no panel, of the same Committee considering the matter;

However, Council Members and Committee Members may discuss any other matter not prohibited by Section 36(1) of the RHPA and not arising from an *in camera* meeting;

(i) respecting the boundaries of College staff whose role is not to report to or work for individual Council Members or Committee Members;

(j) being respectful of others and not engaging in behaviour that might reasonably be perceived as verbal, physical or sexual abuse or harassment; and

(k) any other form of misconduct Council may determine.

11.07 Media and Official Communications

(1) Official communications on behalf of the College shall be coordinated through the Registrar.

(2) The President and the Registrar are the authorized spokespersons of the College. On any given issue, they shall consult with one another to determine who will speak on behalf of the College.

(3) The College shall develop an official communications policy.

(4) All communications by the College to the media and to the public shall be consistent with the policies and positions of the College.

11.08 Speaking and Writing Engagements

(1) All requests inviting a Council Member, Committee Member or an employee, contractor or other appointee of the College to represent the College must be provided in writing to the Registrar giving details of the date, time and place, the topic and anticipated length of the presentation.

(2) The Registrar in consultation with the President will accept or decline a request and determine the appropriate representative to address the topic.

(3) The contents of every engagement must be consistent with the approved policies and positions of the College and shall be reviewed in advance by the Registrar.

(4) No person in their capacity as a representative of the College shall receive any payment or benefit related to the engagement. If the payment or gift cannot in the circumstances be gracefully declined, it shall immediately be turned over to the Registrar for the benefit of the College.

(5) Any Council Member, Committee Member or an employee, contractor or other appointee of the College speaking or writing on a topic involving the practise of optometry in a personal capacity must include a disclaimer that they are not speaking/writing as a representative of the College.

PART 12 - REMUNERATION OF ELECTED COUNCIL MEMBERS

12.01 Remuneration Policy of the College

Elected Council Members shall be paid a stipend and be reimbursed by the College for travelling and other expenses reasonably incurred in relation to the performance of their duties as Council Members or Committee Members in accordance with the College's remuneration policy.

PART 13 - COUNCIL

13.01 Council Meetings

(1) Council Meetings shall be held at the College or any other location determined by the Registrar.

(2) The Registrar shall serve as Council's secretary.

(3) At least four Council meetings shall be held in a calendar year. Additional Council meetings may be called by:

(a) Resolution;

(b) the President; or

(c) the written request of a majority of Council Members.

(4) A Council meeting may be held in any manner that allows all Members, along with any members of the public, to participate simultaneously and instantaneously.

(5) Council meetings are open to the public. However, the public may be excluded from any meeting or part of a meeting in accordance with Section 7 of the Code.

(6) Notice of a Council Meeting shall:

(a) be communicated to Council Members as soon as practicable;

(b) be posted at least 14 days before the Council Meeting on the College's website;

(c) be published in English and French; and

(d) contain:

(i) the meeting agenda;

(ii) the date, time and location of the meeting;

(iii) an address and telephone number at which further information about the meeting may be obtained; and

(iv) if the Registrar anticipates that the Council will exclude the public from any meeting or part of a meeting under subsection 7(2) of the Code, the grounds for doing so.

(7) Briefing books containing the information and documentation that will be provided to members of Council shall be posted on the College's website at least three days before any Council meeting. Information and documentation related to meetings or parts of meetings where the Registrar anticipates Council will exclude the public shall not be posted. The failure to give notice or a briefing book, or the non-receipt of any notice or briefing book, shall not invalidate any actions taken by Council at a Council Meeting.

(8) If Council decides to exclude the public from a meeting or a part of a meeting under subsection 7(2) of the Code, it may make orders it considers necessary to prevent the public disclosure of matters disclosed in the meeting, including banning publication or broadcasting of those matters.

(9) Minutes shall be kept for every Council Meeting and shall:

(a) include details of all motions, recommendations, decisions and the grounds for excluding the public from any meeting or part of a meeting;

(b) be circulated to Council Members following the Council Meeting; be approved or amended at the next Council Meeting;

(c) be approved or amended at the next Council Meeting; and

(d) and once approved:

(i) signed by the chair; and

(ii) provided to the Registrar by the chair to be kept with the College's records.

13.02 Meeting Agenda

(1) During a Council Meeting, Council may only consider:

(a) matters on the agenda; and

(b) any other matter that the majority of Council Members in attendance determine to be of an urgent nature.

(2) A Council Meeting agenda may include:

(a) a discussion of any potential conflict of interest involving a Council Member;

(b) the review for approval or amendment of the minutes of a previous Council Meeting;

(c) review Committee reports and recommendations;

(d) any matter requiring Council's decision or direction;

(e) motions to be tabled at the meeting;

(f) any other matters determined by the President.

13.03 Chair

(1) The President shall chair Council Meetings. However, Council may by Resolution appoint anyone else to preside as chair of a Council Meeting in lieu of the President, provided that, at all times, it does so in good faith and is not in an effort to usurp the function of the President as the presumptive chair of Council Meetings.

(2) In the case of an appointed chair who is a not a Council Member, the chair:

(a) shall not participate in deliberations;

(b) may not vote; and

(c) shall undertake to maintain confidentiality.

13.04 Quorum

(1) A majority of Council Members constitutes a quorum to hold a Council meeting.

(2) In determining whether or not a quorum has been met, the number of Council Members shall be deemed not to be reduced as a result of any vacancy on Council.

13.05 Voting

(1) Every motion shall, depending on the circumstances, be decided by Resolution or Special Resolution.

(2) If the votes cast result in a tie, the chair shall not have a second vote and the motion will be defeated.

(3) Every vote at a Council meeting shall be by a show of hands, roll call, secret ballot or as the chair of the meeting shall otherwise determine. A vote held during a meeting conducted through telecommunications shall be by way of roll call.

(4) In the event of a roll call vote, the Registrar shall record the votes of each Council Member in the minutes of the meeting.

13.06 Written Resolutions

A Written Resolution is as valid and effective as if passed at a Council Meeting.

13.07 Rules of Order of Council Meetings

(1) ***Conduct***

(a) Council Meetings shall be conducted in English.

(b) All attendees shall turn off communications devices during Council Meetings.

(c) Laptops shall only be used during Council Meetings to review materials related to the meeting and to take notes.

(d) No one shall speak out of turn.

(2) ***General Procedure***

(a) Council may informally discuss a matter without the requirement of a motion.

(b) Council may decide matters by consensus or any other informal method. However, a motion should be made if it is Council's intention to vote on a matter.

(c) College staff and consultants with expertise in a matter before Council may be permitted by the chair to answer specific questions.

(d) Non-Council Members are not permitted to speak at a Council Meeting without the prior permission from the President or chair.

(e) However, the President or chair may at any time request a non-Council Member to speak.

(3) ***Motions***

(a) Before a matter may be voted on:

(i) it must be introduced by a Council Member;

(ii) Council Members must have an opportunity to debate it; and

(iii) a motion regarding the matter must be tabled and seconded.

(b) When a motion is being debated, no other motion can be tabled except to:

(i) amend it;

(ii) postpone it;

(iii) vote on it;

(iv) adjourn the debate or the Council meeting; or

(v) refer the motion to a Committee.

(c) The chair shall put the motion to a vote when:

(i) the debate on a matter has concluded;

(ii) Council has passed a motion to vote on the motion; or

(iii) when the time allocated to the debate of the matter has concluded.

(d) During a Council vote:

(i) no Council Member shall enter or leave the room; and

(ii) no further debate is permitted.

(e) When a motion contains multiple matters that are distinct, any Council Member may revise the motion so that each matter is tabled separately.

(f) After a motion has been decided upon, no Council Member may introduce the same or similar motion during the same session of Council unless the majority of Council agrees.

(g) Whenever the chair is of the opinion that a motion tabled by a Council Member is contrary to these By-laws:

(i) the chair shall rule the motion out of order;

(ii) the chair shall give reasons for doing so; and

(iii) the secretary shall record such reasons in the meeting minutes.

(4) ***Amendment of Motions***

(a) A Council Member may only table a motion to amend a motion that has already been tabled (but not yet voted upon) if it:

(i) is relevant to the motion that has already been tabled; and

(ii) does not negate the purpose of the initial motion.

(b) A motion to amend the initial motion shall be debated and voted upon before the initial motion is voted upon.

(c) When there is more than one motion to amend the initial motion, the motions shall be debated and voted upon in the reverse order in which they were tabled.

(5) ***Maintaining Order***

(a) The chair shall maintain order and decide questions of order. If a Council Member disagrees with the chair's ruling, the ruling may be appealed to Council.

(b) The chair may limit:

(i) the number of times a Council Member may speak;

(ii) the length of time a Council Member may speak; and

(iii) impose any other reasonable restrictions to maintain order and efficiency.

(6) ***Other***

(a) The Rules of Order of Meeting may be relaxed by the chair if greater informality is required.

(b) In situations not provided for in these By-laws, the most recent edition of *Robert's Rules of Order* shall be followed.

PART 14 - COMMITTEES

14.01 Committee Meetings

(1) Committee meetings shall be conducted in English.

(2) Each Committee shall meet at the direction of the Committee chair or the majority of Committee Members.

(3) The conduct of Committee Meetings shall be held in accordance with the most recent edition of *Robert's Rules of Order*.

(4) A Committee Meeting may be held in any manner that allows all persons to participate simultaneously and instantaneously.

(5) No formal notice is required for a Committee meeting. However, College staff designated to assist a Committee shall make reasonable efforts to provide notice of each meeting to Committee Members.

(6) Every motion considered by a Committee shall be decided by a majority of the votes cast at the meeting. If the votes cast result in a tie, the chair shall not have a second vote and the motion will be defeated.

(7) Minutes shall be kept for every Committee Meeting and shall:

(a) include details of all motions, recommendations and decisions;

(b) be circulated to Committee Members following the Committee Meeting;

(c) be approved or amended at the next Committee Meeting; and

(d) once approved:

(i) signed by the chair; and

(ii) provided to the Registrar by the chair to be kept with the College's records.

(8) Committees shall provide Council with reports:

(a) annually; and

(b) when requested to do so by either the Executive Committee or Council.

14.02 Executive Committee

(1) The Executive Committee shall be composed of:

(a) an odd number of persons;

(b) one more Elected Council Member than Appointed Council Members;

(c) no more than five Council members, including:

(i) the President; and

(ii) the Vice-President.

(2) The Executive Committee is directly accountable to Council and indirectly accountable to the government, the public and the profession for the effective governance of the College.

(3) The Executive Committee's duties include:

(a) exercise the full powers of Council in all matters of administrative urgency (including cases of unauthorized practice), reporting every action at the next meeting of Council;

(b) review and approve the agenda for Council meetings, as prepared by the Registrar in consultation with the President, for clarity and priority, identify items for which Council meetings may be closed to observers in accordance with s. 7(2) of the *Health Professions Procedural Code* and recommend closure, with rationale, to Council;

(c) review selected briefing materials for Council for clarity, comprehensiveness, and planning the appropriate approach for presentations;

(d) call special meetings of Council;

(e) provide feedback and support to committees and Council as requested;

(f) assist Council members, committees and the Registrar in resolving internal conflicts;

(g) monitor legislation of the federal and provincial government through facilitating College input to relevant legislation proposals and the assessment of relevant new legislation;

(h) coordinate an effective liaison with external government, private and non-profit sector bodies/agencies, including international, national and provincial optometric and health care organisations;

(i) coordinate an appropriate public relations program through the development of targeted public communication efforts;

(j) facilitate the development of protocol agreements with other agencies to maximize inter-agency cooperation to pursue College goals and strategic direction;

(k) provide guidance and support to the Registrar; and

(l) serve as an informal resource to the Registrar, at their request.

(4) Between Council Meetings, the Executive Committee has all the powers of Council with respect to any matter that, in the opinion of the Executive Committee, requires immediate attention. However, the Executive Committee does not have the power to make, amend or revoke a regulation or by-law.

(5) The President is the chair of the Executive Committee.

(6) The Registrar is the secretary of the Executive Committee.

(7) Executive Committee meetings are closed to the public. However, the Executive Committee may permit anyone to attend or participate in meetings.

14.03 Registration Committee

(1) The Registration Committee shall be composed of a minimum of five persons, including at least:

(a) one Elected Council Member;

(b) two Appointed Council Members; and

(c) two Members who may or may not be Council Members.

(2) A panel of the Registration Committee shall be composed of at least three Committee Members, at least one of whom is an Appointed Council Member. The Committee chair will select the panels and appoint the chair for each panel.

14.04 Inquiries, Complaints and Reports Committee

(1) The Inquiries, Complaints and Reports Committee ("ICRC") shall be composed of at least 10 persons, including at least:

(a) four Appointed Council Members;

(b) one Elected Council Member; and

(c) five Members who may or may not be Council Members.

(2) A panel of the ICRC shall be composed of at least three Committee Members, at least one of whom is an Appointed Council Member. The Committee chair will select the panels and appoint the chair for each panel.

14.05 Discipline Committee

(1) The Discipline Committee shall be composed of:

(a) all elected Council Members who are not members of the ICRC;

(b) all appointed Council Members; and

(c) at least five Members who are not Council Members.

(2) A panel of the Discipline Committee shall be composed of at least three and no more than five Committee Members, at least two of whom are Appointed Council Members. The Committee chair will select the panels and appoint the chair for each panel.

14.06 Fitness to Practise Committee

(1) The Fitness to Practise Committee shall be composed of at least three persons, including:

(a) one Elected Council Member;

(b) one Appointed Council Member; and

(c) one Member who may or may not be a Council Member.

(2) No person may be selected for a panel of the Fitness to Practise Committee who has taken part in an investigation or decision made by the ICRC that is to be the subject-matter of the Fitness to Practise panel's hearing.

(3) A panel of the Fitness to Practise Committee shall be composed of at least three Committee Members, at least one of whom is an Appointed Council Member. The Committee chair will select the panels and appoint the chair for each panel.

14.07 Quality Assurance Committee

(1) The Quality Assurance Committee shall be composed of at least thirteen persons, including:

(a) two Elected Council Members;

(b) three Appointed Council Members; and

(c) eight Members who may or may not be Council Members.

(2) A panel of the Quality Assurance Committee shall be composed of at least three Committee Members, at least one of whom is an Appointed Council Member. The Committee chair will select the panels and appoint the chair for each panel.

14.08 Patient Relations Committee

The Patient Relations Committee shall be composed of at least seven persons, including:

(a) one Elected Council Member;

(b) three Appointed Council Members; and

(c) three Members who may or may not be Council Members.

14.09 Ad Hoc and Standing Committees

Council may, by Resolution, appoint and fill such Ad Hoc and/or Standing Committees as it deems necessary.

14.10 Committee Chairs and Panel Chairs

(1) The term of a Committee chair is 1 year.

(2) With the exception of the President as chair of the Executive Committee, no person may serve as a Committee chair for more than 3 consecutive years.

(3) When a panel chair is not able to attend a meeting, hearing or proceeding of a panel, the remaining panel members shall designate a chair for the duration of the absence.

14.11 Quorum for Committees and Panels

(1) The quorum for any:

(a) Committee Meeting is a majority of that Committee's Members; and

(b) panel of a Committee is at least three panel members, at least one of whom shall be an Appointed Council Member.

(2) In determining whether or not a quorum has been met, the number of Committee Members or panel members shall be deemed not to be reduced as a result of any vacancy.

PART 15 - RULES, POLICIES AND CODE OF ETHICS

15.01 Creating Rules and Policies

The College may create rules, policies and similar guiding documents to govern the College and the conduct of its Members, Council Members, Committees and panels.

15.02 Code of Ethics

(1) All Members shall act in accordance with the College's Code of Ethics.

(2) The College's Code of Ethics for all Members includes:

(a) General Responsibilities

(i) The first priority for a Member should be their patient's visual well-being and the provision of appropriate care for all of their patients.

(ii) Members shall:

(A) treat all patients with respect;

(B) practise optometry with competence;

(C) recognize their limitations;

(D) when indicated, recommend that additional opinions and services be sought;

(E) be prepared to collaborate with colleagues in the care of patients; and

(F) engage in lifelong learning to maintain and improve their professional knowledge, skills and judgment.

(iii) Members shall not:

(A) exploit their patients for personal advantage; or

(B) discriminate against any patient.

(b) Communication, Decision-Making and Consent

(i) Members shall:

(A) make reasonable efforts to inform their patients of the diagnosis, prognosis, choices of care and diagnostic and therapeutic procedures in a manner which allows them to make fully informed decisions concerning their care.

(B) respect the informed decisions of their patients.

(c) Confidentiality

(i) Members shall:

(A) whenever possible maintain all of their patients' personal information in confidence. In the rare circumstances, when a Member is required to breach this confidence, the Member shall promptly inform the patient.

(B) when acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature of the Members role.

(d) Clinical Research

(i) Members shall:

(A) ensure that any research a Member conducts has been evaluated scientifically and ethically, is approved by a responsible committee and is sufficiently planned and supervised such that research subjects are unlikely to suffer disproportionate harm.

(B) fully inform the potential research subject about the purpose of the study, its source of funding, the risk and benefits, and the nature of the Member's participation.

(C) before proceeding with the study, obtain the informed consent of the subject and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.

(e) Responsibility to Society

(i) Members shall:

(A) make efforts to provide persons in need with optometric care.

(B) share in the profession's responsibility to society in matters relating to public health, health education, environmental protection, and legislation affecting the health or well-being of the community.

(C) use health care resources prudently.

(f) Responsibility to the Profession

(i) Members shall:

(A) avoid impugning the reputation of colleagues.

(B) attempt to resolve disputes with colleagues in a respectful way.

(g) Responsibility of Oneself

Members shall seek help for problems that may adversely affect service to patients.

PART 16 - INFORMATION PROVIDED BY MEMBERS

16.01 Member Obligations to Provide Information

(1) Upon written request for information by the College, a Member shall respond in writing within the time provided.

(2) A Member shall provide written notice of any change to information previously provided to the College within 14 days of the change.

16.02 Member Reports

(1) A Member's certificate of registration must be renewed annually.

(2) The College shall send a member report to each Member by mail or e-mail requesting any information required by the Registrar and provide the Members with at least 30 days to respond.

(3) The College may request:

(a) the Member's birth date;

(b) the Member's certificate of registration number;

(c) the Member’s e-mail address;

(d) the address and telephone number of each Member's principal residence;

(e) the name of each business where the Member practises optometry, including the address, telephone number, fax number and e-mail address;

(f) the preferred address for receiving College communications;

(g) information respecting the Member's participation in continuing professional development and other professional training;

(h) whether the member is licenced or registered to practice another profession either inside or outside Ontario;

(i) information about actions taken by other regulatory bodies against the Member;

(j) information relating to a finding of professional negligence or malpractice made against the Member;

(k) information related to findings of guilt for a federal, provincial or other offence;

(l) information related to any current charges in respect of a federal, provincial or other offence;

(m) information related to any current existing conditions, terms, orders, directions or agreements relating to the custody or release of the Member with respect to federal, provincial or other offences;

(n) the nature of the Member's practise and services a Member may offer in their practice such as:

(i) ADP Authorizer;

(ii) Automated Visual Fields;

(iii) Binocular Vision Training;

(iv) Contact Lens Therapy;

(v) Corneal Topography;

(vi) Digital Retinal Imaging;

(vii) Home Visits;

(viii) Infant Examinations (0 to 24 months);

(ix) Institution Visits;

(x) Low Vision Therapy;

(xi) Occupational Safety Eyewear;

(xii) Optical Coherence Tomography/Retinal Tomography;

(xiii) Orthokeratology;

(xiv) Pre-School Children (2 to 5 years);

(xv) Punctal Occlusion;

(xvi) Refractive Surgery Co-management;

(xvii) Spectacle Therapy;

(xviii) Sports Vision; and

(xix) Visual Perception Testing and Therapy;

(o) whether the Member prefers to communicate with the College in English or French;

(p) the Member's electoral district;

(q) the number of hours of direct patient care;

(r) information that the College is required to maintain in the register;

(s) a copy of the declarations page from the Member's professional liability insurance policy setting out:

(i) the coverage amount;

(ii) the name of the insurer;

(iii) the policy term; and

(iv) the policy number;

(t) information which allows the College to maintain statistics related to the College and the Member; and

(u) any other information the College requires.

(4) If a Member fails to return a completed member report to the College within the time provided (which shall be not less than 30 days), the Registrar shall:

(a) notify the Member in writing of such failure; and

(b) provide the Member with a reasonable period to return a completed member's report to the College.

(5) If the Member fails to rectify the failure within the time provided, the College may, without notice, suspend the Member's certificate of registration until a completed member report is returned.

(6) A Member must advise the Registrar in writing of a change to any information required for issuance of a certificate of registration within 14 days of such change. The College may, depending on the change of information:

(a) issue a revised certificate of registration;

(b) decline to revise the existing certificate of registration; or

(c) revoke a certificate of registration.

PART 17 - INFORMATION PROVIDED BY HEALTH PROFESSION CORPORATIONS

17.01 Application of a Health Profession Corporation

(1) A health profession corporation is eligible to hold a certificate of authorization if:

(a) the articles of the corporation provide that the corporation cannot carry on a business other than the practise of optometry and activities related to or ancillary to the practise of optometry;

(b) all of the issued and outstanding shares of the corporation are legally and beneficially owned, directly or indirectly, by one or more Members; and

(c) all the requirements set out in the *Ontario Business Corporations Act*, the RHPA, the Act and in and any other applicable statute or regulation, and these By-laws have been satisfied.

(2) In order to obtain a certificate of authorization, a health profession corporation shall apply to the College. The application must include:

(a) the name of the health profession corporation;

(b) all business names of the corporation, if any;

(c) all phone numbers, fax numbers and addresses of all business locations along with the address of its head office;

(d) the capital structure of the corporation and shareholdings of each shareholder;

(e) the name, phone number, address, e-mail address and, when applicable, the College registration number of each shareholder;

(f) the name, phone number, address, e-mail address and, when applicable, the College registration number of each director and officer;

(g) a certified copy of the corporation's:

(i) articles of incorporation, continuance and/or amalgamation, as applicable; and

(ii) by-laws;

(h) a corporation profile report that has been issued no more than 30 days before submitting the application indicating that the corporation has not been dissolved;

(i) a statutory declaration of a director of the corporation, executed not more than 15 days before submitting the application, certifying that:

(i) the corporation complies with Section 3.2 of the *Ontario Business Corporations Act*, and its regulations;

(ii) the corporation does not carry on, and does not plan to carry on, any business that is not the practise of optometry or practises related to or ancillary to the practise of optometry;

(iii) there has been no change in the status of the corporation since the date of the certificate of status; and

(iv) the information contained in the application is complete and accurate as of the date the statutory declaration is executed;

(j) any other information the College deems necessary; and

(k) the signature of all shareholders of the health profession corporation.

17.02 Corporate Reports

(1) A certificate of authorization must be renewed annually and it is the responsibility of the health profession corporation to ensure that the required documentation and fee(s) for the renewal are submitted to the College on or before the renewal date.

(2) The date of renewing a certificate of authorization shall be no more than 30 days before the anniversary or renewal date and the health professional corporation, not the College, shall bear the responsibility for keeping track of the renewal date.

(3) The College shall communicate with each health profession corporation by mail or e-mail requesting any information required by the Registrar and provide the health profession corporation with at least 30 days to respond.

(4) If a health profession corporation fails to return a completed corporate report to the College within the time provided, the Registrar may:

(a) notify the health profession corporation in writing of such failure;

(b) provide the health profession corporation with at least 60 days to return a completed corporate report to the College; and

(c) advise the health profession corporation that failure to return a completed corporate report to the College will result in revocation of the health professional corporation's certificate of authorization.

(5) A health profession corporation must advise the Registrar in writing of a change to any information required for issuance of a certificate of authorization within 14 days of such change. The College may, depending on the change of information:

(a) issue a revised certificate of authorization;

(b) decline to revise the existing certificate of authorization; or

(c) revoke a certificate of authorization.

17.03 Health Profession Corporation Obligations to Provide Information

(1) Upon written request for information from the College, a health profession corporation shall respond in writing within the time provided.

(2) A health profession corporation shall provide written notice of any change to information previously provided to the College within 14 days of the change.

PART 18 - REGISTER

18.01 Maintaining the Register

The Registrar shall maintain a register on behalf of the College in an up to date manner.

18.02 Information that the Code Requires be Kept in the Register

Under subsection 23(2) of the Code and subject to certain exceptions contained in the Code, certain information must be contained in the register and must be available to the public.

(1) each Member's name, business address and business telephone number, and, if applicable, the name of every health profession corporation of which the member is a shareholder;

(2) where a member is deceased, the name of the deceased member and the date upon which the member died, if known to the Registrar;

(3) the name, business address and business telephone number of every health profession corporation;

(4) the names of the shareholders of each health profession corporation who are Members;

(5) the Member's class of registration and specialist status (specialist status not applicable to the College at this time);

(6) the terms, conditions and limitations that are in effect on each Member's certificate of registration;

(7) a notation of every caution that a member has received from a panel of the Inquiries, Complaints and Reports Committee under paragraph 3 of subsection 26 (1);

(8) a notation of any specified continuing education or remedial programs required by a panel of the Inquiries, Complaints and Reports Committee using its powers under paragraph 4 of subsection 26 (1);

(9) a notation of every matter that has been referred by the ICRC to the Discipline Committee under Section 26 of the Code and that has not been finally resolved, including the date of the referral and the status of the hearing before a panel of the Discipline Committee, until the matter has been resolved;

(10) a copy of the specified allegations against a member for every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee under section 26 and that has not been finally resolved;

(11) the result of every disciplinary and incapacity proceeding;

(12) a notation and synopsis of any acknowledgements and undertakings in relation to matters involving allegations of professional misconduct or incompetence before the Inquiries, Complaints and Reports Committee or the Discipline Committee that a member has entered into with the College and that are in effect;

(13) a notation of every finding of professional negligence or malpractice, which may or may not relate to the Member's suitability to practise, made against the Member, unless the finding is reversed on appeal;

(14) a notation of every revocation or suspension of a certificate of registration;

(15) a notation of every revocation of a certificate of authorization;

(16) information that a panel of the Registration Committee, Discipline Committee or Fitness to Practise Committee specifies shall be included in the register;

(17) where findings of a panel of the Discipline Committee are appealed, a notation that they are under appeal, until the appeal is finally disposed of;

(18) where, during or as a result of a proceeding under Section 25 of the Code, the Member has resigned and agreed never to practise again in Ontario, a notation of the resignation and agreement;

(19) where the College is aware that the Member is currently licenced or registered to practise another profession inside or outside of Ontario, a notation of that fact;

(20) where the College is aware that a finding of professional misconduct or incompetence or a similar finding has been made against a Member registered or licensed to practise a profession inside or outside of Ontario, and that finding has not been reversed on appeal,

(a) a notation of that fact;

(b) the name of the governing body that made the finding;

(c) the date the finding was made if available;

(d) a brief summary of the facts on which the finding was based if available;

(e) the order made if available; and

(f) information regarding any appeals of the finding or order if available;

(21) where the College is aware that a finding of incapacity or similar finding has been made against a Member registered or licensed to practise a profession inside or outside of Ontario, and that finding has not been reversed on appeal,

(a) a notation of the finding;

(b) the name of the governing body that made the finding;

(c) the date the finding was made if available;

(d) a summary of any order made if available; and

(e) information regarding any appeals of the finding or order if available;

(22) any existing conditions of release, of which the College is aware, following a charge for an offence under the *Criminal Code (Canada)* or *Controlled Drugs and Substances Act (Canada)* or subsequent to a finding of guilt and pending appeal or any variations to those conditions.

(23) any outstanding charge for an offence, of which the College is aware, under the *Criminal Code (Canada)* or the *Controlled Drug and Substances Act (Canada)* including the following information

(a) the fact and content of the charge; and

(b) the date and place of the charge;

(24.1) any findings of guilt, of which the College is aware, under the *Criminal Code (Canada)*or *Controlled Drugs and Substances Ac (Canada)t,* including the following information unless the conditions in subsection 24.2 apply:

(a) a summary of the finding;

(b) a summary of the sentence; and

(c) if the finding is under appeal, a notation that it is under appeal until the appeal is disposed of;

(24.2) the conditions where a finding of guilt referred to in subsection (24.1) shall not be entered on the register are as follows:

(a) The Parole Board has ordered a record suspension in respect of the conviction;

(b) A pardon in respect to the conviction has been obtained; or

(c) The conviction has been overturned on appeal.

(25) information that is required to be kept in the register in accordance with regulations made pursuant to clause 43 (1) (t) of the *Regulated Health Professions Act, 1991*; and

(26) any other information that is required to be kept in the register in accordance with these By-laws.

18.03 Additional Information that the College Requires Be Kept in the Register

For the purposes of paragraph 20 of subsection 23(2) of the Code, and subject to sections 18.05 and 18.06, the register shall contain the following information, which is designated by the College as public pursuant to subsection 23(5) of the Code:

(1) the Member's gender;

(2) the date that the Member first became a Member or, if the Member was licensed under the *Health Disciplines Act*, the date when the Member was first issued a licence by the College;

(3) each Member's certificate of registration number and the date it was issued;

(4) a description of the Member's degree in optometry (or equivalent academic achievement) held by the Member and the year the Member obtained the degree (or equivalent academic achievement);

(5) any language in which the Member is able to communicate and provide services to patients;

(6) the name and address of any optometric practice for which the Member is an employee, contractor or otherwise. This includes any optometric practice where the member works as a locum;

(7) if applicable, a notation concerning the authorization by the College to prescribe drugs, and the date on which the Member received such authorization;

(8) each Member's certificate of authorization, including:

(a) the name of the corporation; and

(b) the date it was issued;

(9) upon revision of a certificate of registration or certificate of authorization:

(a) details of the revision; and

(b) the effective date of the revision;

(10) the effective date of resignation of the Member;

(11) a summary of any current charges against a Member, other than those required by Part 18.02, of which the College is aware in respect of a federal, provincial or other offence that the Registrar believes is relevant to the Member’s suitability to practise;

(12) a summary of any currently existing conditions, terms, orders, directions or agreements relating to the custody or release of the Member in provincial, federal or other offence processes, other than those required by Part 18.02, of which the College is aware and that the Registrar believes is relevant to the Member’s suitability to practise;

(13) a summary of any findings of guilt, other than those required by Part 18.02, of which the College is aware if made by a court after January 17, 2015, against a Member in respect of a federal, provincial or other offence that the Registrar believes is relevant to the Member’s suitability to practice;

(14) where the Member’s certificate of registration is subject to any terms, conditions and limitations, the reason for them, the Committee that imposed them and the date they took effect;

(15) where terms, conditions or limitations on the Member’s certificate of registration have been varied or removed, the effective date of the variance or removal of those terms, conditions and limitations;

(16) where the Member's certificate of registration is subject to a suspension for failure to pay a fee, the reason for the suspension and the date of the suspension in addition to the fact of the suspension;

(17) where a suspension of the Member's certificate of registration is lifted or otherwise removed, the effective date of the lifting or removal of that suspension;

(18) where the Member's certificate of registration is reinstated, the effective date of the reinstatement;

(19) where a finding of professional negligence or malpractice is contained in the College's register, the following information;

(a) the date of the finding;

(b) the court and the court file number;

(c) a summary of the finding; and

(d) the status of any appeal respecting the finding made against the Member;

(20) where applicable, a summary of any restriction on the Member's right to practise:

(a) resulting from an undertaking given by the Member to the College or an agreement entered into between the Member and the College; or

(b) of which the College is aware and which has been imposed by a court or other lawful authority, in which event the summary of the restriction shall also include the source of the restriction;

(21) the following information regarding every caution that a member has received on or after October 1, 2015, from a panel of the Inquiries, Complaints and Reports Committee under paragraph 3 of subsection 26 (1) of the Code;

(a) a notation of that fact,

(b) a summary of the panel's decision, including a summary of the caution,

(c) the date of the panel's decision, and

(d) if applicable, a notation that the panel's decision is subject to review and therefore is not yet final, which notation shall be removed once the review is finally disposed of;

(22) the following information regarding any specified continuing education or remediation program that has been required by the Inquiries, Complaints

and Reports Committee on or after October 1, 2015 under paragraph (4) of subsection 26(1) of the Code,

(a) a notation of that fact,

(b) a summary of the panel's decision, including a summary of the specified continuing education or remediation program,

(c) the date of the panel's decision, and

(d) if applicable, a notation that the panel's decision is subject to review and therefore is not yet final, which notation shall be removed once the review is finally disposed of.

(23) the following information regarding any undertaking that the member has been directed to comply with by the Inquiries, Complaints and Reports Committee on or after October 1, 2015 under paragraph (4) of subsection 26(1) of the Code:

(a) a notation of that fact;

(b) a summary of the panel's decision, including a summary of the undertaking; and

(c) the date of the undertaking and of the panel's decision;

(24) where the Member's certificate of registration is subject to an interim order of the ICRC, a notation of that fact, the nature of that order and its effective date;

(25) where an allegation of a Member's professional misconduct or incompetence has been referred to the Discipline Committee or where the Registrar has referred an application for reinstatement to the Discipline Committee under section 73 of the Code and the matter is outstanding,

(a) the date of the referral;

(b) a brief summary of each specified allegation, if applicable;

(c) the notice of hearing;

(d) the anticipated date of the hearing, if the hearing date has been set or the next scheduled date for the continuation of the hearing if the hearing has commenced;

(e) if the hearing is awaiting scheduling, a statement of that fact; and

(f) if the hearing of evidence and arguments is completed and the parties are awaiting a decision of the Discipline Committee, a statement of that fact;

(26) where a decision of the Discipline Committee has been published by the College with the Member's name:

(a) a notation of that fact; and

(b) identification of the specific publication of the College which contains the information;

(27) the reasons for decision of every disciplinary proceeding:

(a) in which a panel of the Discipline Committee makes a finding of professional misconduct or incompetence; and

(b) in which a panel of the Discipline Committee makes no finding with regard to the proceeding but the Member requests that the reasons be posted in the register;

(28) where the question of a Member's capacity has been referred to the Fitness to Practise Committee or where the Registrar has referred an application for reinstatement to the Fitness to Practise Committee under section 73 of the Code and the matter is outstanding:

(a) the date of the referral; and

(b) a notation of the referral.

(29) where the College is aware that a pending allegation of professional misconduct or incompetence or a similar allegation has been referred to a discipline type of hearing against a Member registered or licensed to practise a profession inside or outside of Ontario and the Registrar believes that it is relevant to the Member's suitability to practise,

(a) a notation of that fact;

(b) the name of the governing body that made the referral;

(c) the date of the referral if available;

(d) a brief summary of each allegation if available; and

(e) the notice of hearing if available.

(30) in respect of a former Member, any information that was in the register at the time the former Member's registration terminated, for a period of at least two years after the termination of registration, except for any information related to discipline proceedings in Ontario, which shall be entered in the register for a period of 50 years after the termination of registration; and

(31) any other information not otherwise referred to in this section, which the College and the Member have agreed shall be available to the public.

18.04 Designated Information for Safety Exception

(1) All of the information required to be kept in the register under subsection 23(2) of the Code and all of the information kept in the register under 18.03 of these By-laws is designated as information that may be withheld from the public pursuant to subsection 23(6) of the Code if the Registrar has reasonable grounds to believe that disclosure of that information may jeopardize the safety of an individual.

18.05 Deletion of Information

(1) Notwithstanding section 18.03, where after a review the ICRC has been required to remove or vary the requirement to appear for a caution or to complete a specified continuing education or remediation program:

(a) the Registrar may delete from the register any information which would otherwise have been required to be maintained under section 18.03(23) or section 18.03(24); and

(b) the Registrar may enter a summary of the process leading up to and the results of any variation of a caution or a specified continuing education or remediation program.

18.06 Publication Ban and Disclosure

(1) Pursuant to Section 23(3) of the Code, no action shall be taken by the College with respect to information that would violate a publication ban.

(2) The Registrar may refuse to disclose or post on the College's website information that is otherwise required to be public if:

(a) the Registrar has reasonable grounds to believe that such disclosure may jeopardize the safety of an individual; or

(b) the Registrar has reasonable grounds to believe that the information is obsolete and no longer relevant to a Member's suitability to practise.

(3) The Registrar shall not disclose or post on the College's website information that is otherwise required to be public if it is personal health information, unless it is the personal health information of a Member and it is in the public interest that such information be disclosed. Any disclosure of a Member's personal health information shall be limited to not more than what is reasonably necessary. For the purposes these By- laws, "personal health information" means information that identifies an individual and that is referred to in clauses (a) through (g) of the definition

of "personal health information" in subsection 4(1) of the *Personal Health Information Protection Act, 2004*.

(4) The Registrar shall refuse to disclose information regarding a Member relating to disciplinary or incapacity proceeding if:

(a) a finding of professional misconduct was made against a Member and the order made was only a reprimand or only a fine, or a finding of incapacity was made against a Member;

(b) more than 6 years have passed since the information was prepared or last updated;

(c) the Member has made an application to the relevant Committee for the removal of the information from public access because the information is no longer relevant to the Member's suitability to practise, and if:

(i) the relevant Committee believes that a refusal to disclose the information outweighs the desirability of public access to the information in the interest of any person affected or the public interest; and

(ii) the relevant Committee has directed the Registrar to remove the information from public access; and

(d) the information does not relate to disciplinary proceedings concerning sexual abuse as defined in clause (a) or (b) of the definition of "sexual abuse" in Subsection 1(3) of the Code.

(5) The Registrar shall refuse to disclose to an individual or to post on the College's website information required by paragraph 11 of section 18.02 if

(a) the result of a discipline proceeding was that no finding of professional misconduct or incompetence was made against the member; and

(b) more than 90 days have passed since the information was prepared or last updated, unless before the expiry of the 90 days the member to whom the information relates specifically requests in writing that the Registrar continue to maintain public access to the information.

PART 19 - LIFE MEMBERS

(1) A Member or a former Member may apply to the College to be designated as a Life Member by the College's Registrar;

(2) A Member or a former Member is eligible to be a Life Member if they:

(a) hold or have ever held a general certificate of registration or academic certificate of registration with the College for at least 25 years;

(b) have retired from practising optometry;

(c) were in good standing with the College when they resigned their membership with the College;

(d) are not a Council Member;

(e) after having been provided with an opportunity to rectify any failure of their obligations to the College:

(i) have paid any fee, penalty or order for costs owing to the College;

(ii) have submitted to the College all required forms and documents; and

(iii) are otherwise in good standing with the College;

(f) have not had their certificate of registration suspended or revoked in the previous 6 years;

(g) have not had a term, condition or limitation on their certificate of registration in the previous 6 years other than one that does not already apply to every Member who possesses that class of certificate;

(h) are not the subject of any disciplinary or incapacity proceedings; and

(i) have not otherwise acted in a manner that is inconsistent with an ongoing association with the College.

(3) A Life Member shall not:

(a) practise optometry;

(b) hold themself out as qualified to practise optometry in Ontario; or

(c) be eligible for election to Council or vote in Council elections.

(4) A Life Member's designation may be revoked by the Registrar if the Life Member:

(a) is found by a panel of the Discipline Committee to be incompetent or to have committed an act of professional misconduct;

(b) acts in a manner that is inconsistent with an ongoing association with the College provided that, before making a determination, the Registrar first

provides the Life Member with a reasonable opportunity to make written submissions; or

(c) after having been provided with an opportunity to rectify any failure in their obligations to the College:

(i) remain in default of any fee, charge or order for costs owing to the College,

(ii) fail to submit to the College all required forms and documents, or

(iii) cease to otherwise be in good standing with the College.

(5) A Life Member who wishes to re-obtain a general or academic certificate of registration must apply for one and meet the registration requirements in effect at the time of application.

PART 20 - FUNDING FOR THERAPY AND COUNSELLING

20.01 Sexual Abuse Funding Program

(1) The College shall establish funding for therapy and counselling for persons who, while patients of a Member, were sexually abused by the Member (the "Sexual Abuse Funding Program").

(2) The definition of "sexual abuse" is set out in Section 1(3) of the *Code.*

20.02 Role of Patient Relations Committee

The Patient Relations Committee shall:

(1) administer the Sexual Abuse Funding Program;

(2) determine the eligibility of an individual for funding based on whether:

(a) it is alleged, in a complaint or report, that the person was sexually abused by a Member while the person was a patient of the Member;

(b) the individual confirms that the therapy will be at least partially related to the sexual abuse committed by the Member. However, the individual is not required to undergo a psychological or other assessment before receiving funding;

(c) the funding will only be used by the individual for therapy or counselling. The College may request signed receipts from the therapist or counsellor, and all payments for therapy or counselling shall be made by the College directly to the therapist or counsellor; and

(d) the individual's therapist or counsellor;

(i) does not have a family relationship with the individual; and

(ii) is not a person who has, at any time or in any jurisdiction, been found guilty of professional misconduct of a sexual nature, or been found civilly or criminally liable for an act of a similar nature; and

(e) the application for funding is made within the time prescribed under Ontario Regulation 59/94 ("Funding for Therapy or Counselling for Patients Sexually Abused by Members").

20.03 Application Process

(1) To obtain funding, the individual must apply in writing to the College. As part of the application, the College may require that the individual provide the College with:

(i) details of the therapist or counsellor's training, experience and contact information;

(ii) written confirmation that the individual has no family relation to the therapist or counsellor;

(iii) if requested by the College to do so, a document acknowledging that the therapist or counsellor is not a member of a regulated professional and therefore not subject to professional discipline; and

(iv) any other information the College deems necessary.

(2) The maximum amount the College shall fund an individual's therapy or counselling shall be governed by Ontario Regulation 59/94 and Section 85.7(11) of the Code.

(3) Any decision, including reasons, of the Patient Relations Committee to approve or deny funding shall be provided in writing to the individual.

PART 21 - PROFESSIONAL LIABILITY INSURANCE

21.01 Mandatory Insurance for Members

(1) No Member shall engage in the practise of optometry unless they are personally insured against professional liability under a professional liability insurance policy that provides coverage based on when an “occurrence” allegedly took place.

(2) The professional liability insurance policy must provide:

(a) at a minimum, coverage in the amount of:

(i) $2,000,000 per occurrence; and

(ii) $5,000,000 in the aggregate per year; and

(b) a deductible of not more than $5,000.

(3) A Member must, at all times, keep a copy of the Member's professional liability insurance policy at all of their places of business.

PART 22 - FEES AND PENALTIES

22.01 Setting and Imposing Fees and Penalties

(1) The College shall maintain, as a schedule to these By-laws, a list of all fees and penalties which may be charged or imposed by the College. Council may, without amending these By-laws, adjust the amount of any fees or penalties set out in the schedule to reflect annual changes to the Consumer Price Index (Canada) plus up to 2%.

(2) Where no fee or penalty has been set out in the schedule, a Member or person shall pay to the College the fee or penalty set by the College.

22.02 Obligation to Pay Fees and Penalties

(1) A Member's obligation to pay a fee or penalty continues regardless of whether:

(a) the College fails to send notice; or

(b) the Member fails to receive notice;

of a fee or penalty.

(2) The College may waive all or a portion of any fee or penalty.

22.03 Consequences for Failure to Pay Fees and Penalties

(1) Any fee or penalty charged or imposed by the College not paid by a Member shall be included as part of a Member's next annual membership fee.

(2) If a Member fails to pay a fee or penalty or part thereof:

(a) the Registrar must give the Member notice if the College intends to suspend the Member; and

(b) may suspend the Member’s certificate of registration for failure to pay the fee or penalty within 30 days after notice is given.

ENACTED the 3rd day of August 2012

Revised the 4th day of September 2012

Revised the 16th day of January 2015

Revised the 8th day of April 2015

Revised the 30th day of September 2015

Revised the 20th day of January 2016

Fee Schedule Effective the 20th day of April 2016

Fee Schedule Effective the 16th day of January 2017

Revised the 22nd day of June 2017

Revised the 19th of September 2017

Revised the 21st of June 2018

Revised the 27th of September 2019

Fee Schedule Effective the 1st day of January 2020

Revised the 26th day of March 2021

Schedule of Fees and Penalties – effective January 1, 2020

All of the following fees are in Canadian funds and subject to 13% HST.

	Fee
Application Fee including Jurisprudence Seminar and Exam Fee	$420.00
Jurisprudence Reassessment Fee	$184.00
Certificate Fee upon completion of all College registration requirements	$26.00
Duplicate Certificate fee: • when ordered at the same time as the initial certificate • when ordered some time after ordering the initial certificate	 $11.00 $26.00
Annual Membership Fee (non-refundable)	$945.00
Annual Non-Practising Membership Fee (non-refundable)	$472.50
Late Penalty Fee (application, membership renewal, Certificate of Authorization renewal)	$105.00
Reinstatement Fee (membership)	$210.00
Certificate of Authorization (Incorporation) Application Fee	$440.00
Certificate of Authorization (Incorporation) Certificate Fee	$26.00
Certificate of Authorization (Incorporation) Revision	$220.00
Certificate of Authorization (Incorporation) Annual Renewal Fee	$220.00
Quality Assurance Practice Assessment Fee (CRA)	$2,400.00
Quality Assurance Short Record Assessment Fee (for CE deficient hours): • Deficient by 5 hours or less (5 records) • Deficient by more than 5 hours (25 records)	 $1,000.00 $5,000.00
Incorrectly Underreported CE Hours Audit Fee	$350.00
Quality Assurance Evaluation Fee	$3,176.00
Certificate of Standing	$105.00
Address Labels: For members and other professionals on profession-related business (e.g., referrals) For continuing education providers (e.g., UWSO, Vision Institute, University of Toronto) For any commercial organization	 $32.00 $95.00 $315.00
NSF Cheques	$42.00

Fee for Copying and Providing any Requested Documentation	Actual costs to the College of providing the copies

Other Legislation

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Aeronautics Act

Under the federal *Aeronautics Act*, optometrists and physicians are responsible for reporting medical conditions that may create a risk to flight safety. Optometrists should be aware that aviation licence holders must identify themselves as such prior to the examination and in doing so are deemed to have given consent should the optometrist need to report any information. No action may be taken against a physician or optometrist for carrying out their reporting requirements under the *Aeronautics Act* when this involves information obtained during the course of providing professional services to the licence holder. The *Aeronautics Act* does not give protection to practitioners who obtain information in other ways.

The reporting by optometrists is not intended to duplicate the compulsory examinations performed by *Civil Aviation Medical Examiners*. Rather, it is intended to supplement this compulsory system and to ensure that changes in conditions that occur between mandatory examinations are brought to the attention of the responsible authorities.

As to the role of vision in flying and the reporting requirements, the Canadian Medical Association recognizes the following:

The Role of Vision
Good vision is essential for licence holders in all 3 classes. Any marked loss of visual acuity will diminish the ability to perform the required duties in a safe manner.

Requirements
The function of the eyes and their adnexa shall be normal. There shall be no active pathological condition, acute or chronic, of either eye which is likely to interfere with its proper function to an extent that would jeopardize safety in flight or safe performance of duties.

Application of Standards
All standards are based on the applicant's best-corrected vision.
Reportable abnormalities of the visual system:

- change from binocularity to monocularity;
- changes in the field of vision;
- diplopia;
- retinal detachment;
- eye injury affecting visual acuity or fields;
- ortho-keratology; and
- radial keratotomy.

Members of the College are advised that reporting requirements extend to the following groups:

- commercial pilots;
- navigators, engineers and air traffic controllers; and
- private pilots including glider, balloon and ultralights.

Should an optometrist have occasion to examine a patient who holds a licence in one of the above-listed classes and who has what appears to be a reportable condition, he or she is required to make a report available to:

Regional Aviation Medicine Officer
Civil Aviation Medicine
C/0 Transport Canada
4900 Yonge St., Suite 300
NORTH YORK, ON, M2N 6A5
Phone: 416- 952-0562

When reporting is required, the optometrist should provide the full name of the licence holder, date of birth or file number.

If a situation presents in which there is some doubt as to the reportability of a condition, advice may be sought from an Aviation Medical Officer. This can be done without initially identifying the licence holder. An Aviation Medical Officer can be contacted at the above telephone number, and collect calls will be accepted.

Optometrists wishing additional information may request a copy of the brochure "Fit for Flying: A Guide for Mandatory Medical Reporting" from the Canadian Medical Association or contact Health and Welfare Canada at the address above for general information regarding the reporting of medical conditions.

Aeronautics Act

R.S. 1985, c. A-2
(excerpt)

Medical and Optometric Information

Minister to be provided with information
6.5 (1) Where a physician or an optometrist believes on reasonable grounds that a patient is a flight crew member, an air traffic controller or other holder of a Canadian aviation document that imposes standards of medical or optometric fitness, the physician or optometrist shall, if in his opinion the patient has a medical or optometric condition that is likely to constitute a hazard to aviation safety, inform a medical adviser designated by the Minister forthwith of that opinion and the reasons therefor.

Patient to advise
(2) The holder of a Canadian aviation document that imposes standards of medical or optometric fitness shall, prior to any medical or optometric examination of his person by a physician or optometrist, advise the physician or optometrist that he is the holder of such a document.

Use by Minister
(3) The Minister may make such use of any information provided pursuant to subsection (1) as the Minister considers necessary in the interests of aviation safety.

No proceedings shall lie
(4) No legal, disciplinary or other proceedings lie against a physician or optometrist for anything done by him in good faith in compliance with this section.

Information privileged
(5) Notwithstanding subsection (3), information provided pursuant to subsection (1) is privileged and no person shall be required to disclose it or give evidence relating to it in any legal, disciplinary or other proceedings and the information so provided shall not be used in any such proceedings.

Deemed consent
(6) The holder of a Canadian aviation document that imposes standards of medical or optometric fitness shall be deemed, for the purposes of this section, to have consented to the giving of information to a medical adviser designated by the Minister under subsection (1) in the circumstances referred to in that subsection.

Child and Family Services Act

Mandatory reporting of suspected child abuse or neglect

The *Child and Family Services Act* promotes the best interest, protection and wellbeing of children less than 18 years of age. It requires any person, including an optometrist who provides professional services with respect to children, who has reasonable grounds to suspect one of the following, to report a suspicion and the information on which it is based:

1. The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,
   i. failure to adequately care for, provide for, supervise or protect the child, or
   ii. pattern of neglect in caring for, providing for, supervising or protecting the child.

2. There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
   i. failure to adequately care for, provide for, supervise or protect the child, or
   ii. pattern of neglect in caring for, providing for, supervising or protecting the child.

3. The child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.

4. There is a risk that the child is likely to be sexually molested or sexually exploited as described in paragraph 3.

5. The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment.

6. The child has suffered emotional harm, demonstrated by serious,
   i. anxiety,
   ii. depression,
   iii. withdrawal,
   iv. self-destructive or aggressive behaviour, or
   v. delayed development,

   and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of

neglect on the part of the child's parent or the person having charge of the child.

7. The child has suffered emotional harm of the kind described in subparagraph i, ii, iii, iv, or v of paragraph 6 and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.

8. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv, or v of paragraph 6 resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

9. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv, or v of paragraph 6 and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to services or treatment to prevent the harm.

10. The child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to treatment to remedy or alleviate the condition.

11. The child has been abandoned, the child's parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody.

12. The child is less than 12 years old and has killed or seriously injured another person or caused serious damage to another person's property, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to those services or treatment.

13. The child is less than 12 years old and has on more than one occasion injured another person or caused loss or damage to another person's properly with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately.

An optometrist, as a professional working closely with children, has a special awareness of the signs of child abuse and neglect and a particular responsibility to report their suspicions. The requirement is for the individual to report when he or she has reasonable grounds, not when they are absolutely sure that the abuse or neglect has taken place. It is an offence, punishable by conviction or fine, to fail to report.

The optometrist must make the report themselves directly to the local Children's Aid Society (CAS). Reporting responsibilities cannot be delegated to an employee or other person. Furthermore, the *Child and Family Services Act* establishes an ongoing duty to report such that if a person has made a previous report about a child and has additional reasonable grounds to suspect that a child is or may be in need of protection, that person must make a further report to the local CAS.

Child and Family Services Act

R.S.O. 1990, CHAPTER C.11

(excerpt)

DUTY TO REPORT

Duty to report child in need of protection

72. (1) Despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society:

1. The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,
   i. failure to adequately care for, provide for, supervise or protect the child, or
   ii. pattern of neglect in caring for, providing for, supervising or protecting the child.
2. There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
   i. failure to adequately care for, provide for, supervise or protect the child, or
   ii. pattern of neglect in caring for, providing for, supervising or protecting the child.
3. The child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.

Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 3 is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (1) and the following substituted:

3. The child has been sexually molested or sexually exploited, including by child pornography, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.

See: 2008, c. 21, ss. 3 (1), 6.

4. There is a risk that the child is likely to be sexually molested or sexually exploited as described in paragraph 3.
5. The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the

child does not provide, or refuses or is unavailable or unable to consent to, the treatment.

6. The child has suffered emotional harm, demonstrated by serious,
   i. anxiety,
   ii. depression,
   iii. withdrawal,
   iv. self-destructive or aggressive behaviour, or
   v. delayed development,

   and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.
7. The child has suffered emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.
8. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.
9. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and that the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm.
10. The child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, treatment to remedy or alleviate the condition.
11. The child has been abandoned, the child's parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody.
12. The child is less than 12 years old and has killed or seriously injured another person or caused serious damage to another person's property, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, those services or treatment.
13. The child is less than 12 years old and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately. 1999, c. 2, s. 22 (1).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 72 is amended by the Statutes of Ontario, 2008, chapter 21, subsection 3 (2) by adding the following subsections:

Reporting child pornography

(1.1) In addition to the duty to report under subsection (1), any person who reasonably believes that a representation or material is, or might be, child pornography shall promptly report the information to an organization, agency or person designated by a regulation made under clause 216 (c.3). 2008, c. 21, s. 3 (2).

Seeking out child pornography not required or authorized

(1.2) Nothing in this section requires or authorizes a person to seek out child pornography. 2008, c. 21, s. 3 (2).

Protection of informant

(1.3) No action lies against a person for providing information in good faith in compliance with subsection (1.1). 2008, c. 21, s. 3 (2).

Identity of informant

(1.4) Except as required or permitted in the course of a judicial proceeding, in the context of the provision of child welfare services, otherwise by law or with the written consent of an informant, no person shall disclose,

(a) the identity of an informant under subsection (1) or (1.1),

(i) to the family of the child reported to be in need of protection, or

(ii) to the person who is believed to have caused the child to be in need of protection; or

(b) the identity of an informant under subsection (1.1) to the person who possessed or accessed the representation or material that is or might be child pornography. 2008, c. 21, s. 3 (2).

Retaliation against informant prohibited

(1.5) No person shall dismiss, suspend, demote, discipline, harass, interfere with or otherwise disadvantage an informant under this section. 2008, c. 21, s. 3 (2).

See: 2008, c. 21, ss. 3 (2), 6.

Ongoing duty to report

(2) A person who has additional reasonable grounds to suspect one of the matters set out in subsection (1) shall make a further report under subsection (1) even if he or she has made previous reports with respect to the same child. 1999, c. 2, s. 22 (1).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (3) and the following substituted:

Ongoing duty to report

(2) A person who has additional reasonable grounds to suspect one of the matters set out in subsection (1) or to believe that a representation or material is, or might be, child pornography under subsection (1.1) shall make a further report

under subsection (1) or (1.1) even if he or she has made previous reports with respect to the same child. 2008, c. 21, s. 3 (3).
See: 2008, c. 21, ss. 3 (3), 6.

Person must report directly

(3) A person who has a duty to report a matter under subsection (1) or (2) shall make the report directly to the society and shall not rely on any other person to report on his or her behalf. 1999, c. 2, s. 22 (1).
Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (3) is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (3) and the following substituted:
Person to report directly
(3) A person who has a duty to report under subsection (1) or (2) shall make the report directly to the society, a person who has a duty to report under subsection (1.1) shall make the report directly to any organization, agency or person designated by regulation to receive such reports, and such persons shall not rely on any other person to report on their behalf. 2008, c. 21, s. 3 (3).
See: 2008, c. 21, ss. 3 (3), 6.

Offence

(4) A person referred to in subsection (5) is guilty of an offence if,
(a) he or she contravenes subsection (1) or (2) by not reporting a suspicion; and
(b) the information on which it was based was obtained in the course of his or her professional or official duties. 1999, c. 2, s. 22 (2).
Note: On a day to be named by proclamation of the Lieutenant Governor, section 72 is amended by the Statutes of Ontario, 2008, chapter 21, subsection 3 (4) by adding the following subsections:
Same
(4.1) A person is guilty of an offence if the person fails to report information as required under subsection (1.1). 2008, c. 21, s. 3 (4).
Same
(4.2) A person is guilty of an offence if the person,
(a) discloses the identity of an informant in contravention of subsection (1.4); or
(b) dismisses, suspends, demotes, disciplines, harasses, interferes with or otherwise disadvantages an informant in contravention of subsection (1.5). 2008, c. 21, s. 3 (4).
See: 2008, c. 21, ss. 3 (4), 6.

Same

(5) Subsection (4) applies to every person who performs professional or official duties with respect to children including,

(a) a health care professional, including a physician, nurse, dentist, pharmacist and psychologist;
(b) a teacher, school principal, social worker, family counsellor, operator or employee of a day nursery and youth and recreation worker;
(b.1) a religious official, including a priest, a rabbi and a member of the clergy;
(b.2) a mediator and an arbitrator;
(c) a peace officer and a coroner;
(d) a solicitor; and
(e) a service provider and an employee of a service provider. 1999, c. 2, s. 22 (3); 2006, c. 1, s. 2.

Same

(6) In clause (5) (b),
"youth and recreation worker" does not include a volunteer. 1999, c. 2, s. 22 (3).

Same

(6.1) A director, officer or employee of a corporation who authorizes, permits or concurs in a contravention of an offence under subsection (4) by an employee of the corporation is guilty of an offence. 1999, c. 2, s. 22 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (6.1) is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (5) and the following substituted:
Same
(6.1) A director, officer or employee of a corporation who authorizes, permits or concurs in a contravention of an offence under subsection (4) or (4.1) by an employee of the corporation is guilty of an offence. 2008, c. 21, s. 3 (5).
See: 2008, c. 21, ss. 3 (5), 6.

Same

(6.2) A person convicted of an offence under subsection (4) or (6.1) is liable to a fine of not more than $1,000. 1999, c. 2, s. 22 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (6.2) is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (6) and the following substituted:
Penalty
(6.2) A person convicted of an offence under subsection (4), (4.1), (4.2) or (6.1) is liable to a fine of not more than $50,000 or to imprisonment for a term of not more than two years, or to both. 2008, c. 21, s. 3 (6).
See: 2008, c. 21, ss. 3 (6), 6.

Section overrides privilege

(7) This section applies although the information reported may be confidential or privileged, and no action for making the report shall be instituted against a person who acts in accordance with this section unless the person acts maliciously or without reasonable grounds for the suspicion. R.S.O. 1990, c. C.11, s. 72 (7); 1999, c. 2, s. 22 (4).

Exception: solicitor client privilege

(8) Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client. R.S.O. 1990, c. C.11, s. 72 (8).

Conflict

(9) This section prevails despite anything in the *Personal Health Information Protection Act, 2004*. 2004, c. 3, Sched. A, s. 78 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 2008, chapter 21, section 4 by adding the following section:

Action by organization receiving report of child pornography

72.0.1 (1) An organization, agency or person that obtains information on child pornography under subsection 72 (1.1) shall review the report and, if it reasonably believes that the representation or material is or might be child pornography, it shall report the matter to a society or a law enforcement agency, or to both as necessary. 2008, c. 21, s. 4.

Annual report

(2) The organization, agency or person shall prepare and submit to the Minister an annual report with respect to its activities and actions relating to information it obtains on child pornography, and the Minister shall submit the report to the Lieutenant Governor in Council and then table the report in the Assembly if it is in session or, if not, at the next session. 2008, c. 21, s. 4.

See: 2008, c. 21, ss. 4, 6.

Duty of society

72.1 (1) A society that obtains information that a child in its care and custody is or may be suffering or may have suffered abuse shall forthwith report the information to a Director.

Definition

(2) In this section and sections 73 and 75,

"to suffer abuse", when used in reference to a child, means to be in need of protection within the meaning of clause 37 (2) (a), (c), (e), (f), (f.1) or (h). 1999, c. 2, s. 23 (1).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 72.1 (2) is amended by the Statutes of Ontario, 1999, chapter 2, subsection 23 (2) by striking out "sections 73 and 75" and substituting "section 73". See: 1999, c. 2, ss. 23 (2), 38.

Duty to report child's death

72.2 A person or society that obtains information that a child has died shall report the information to a coroner if,

(a) a court made an order under this Act denying access to the child by a parent of the child or making the access subject to supervision;

(b) on the application of a society, a court varied the order to grant the access or to make it no longer subject to supervision; and

(c) the child subsequently died as a result of a criminal act committed by a parent or family member who had custody or charge of the child at the time of the act. 2006, c. 24, s. 1.

Health Care Consent Act

The *Health Care Consent Act* provides a statutory framework that regulates obtaining consent. It has provisions related to consent to treatment, the patient's capacity to provide consent, and substitute decision-makers. It also regulates the information that must be given to a patient or the patient's substitute decision-maker about the proposed treatment.

In the Act, treatment is defined as anything done for a therapeutic, preventive palliative, diagnostic, cosmetic or other health-related purpose. Treatment includes not only therapy, but also diagnostic procedures required to make the diagnosis.

Some exceptions, i.e., procedures for which consent is not required, include the assessment or examination of a person to determine the general nature of the person's condition, taking a person's health history, and communication of an assessment or diagnosis.

Prior to providing their consent, the patient must be given all the information required to make an informed decision about the procedure or treatment. The elements of valid consent include:

- the consent is given voluntarily, not through misrepresentation
- there is an explanation of the potential risks and benefits of the procedure or treatment
- there is an explanation of the nature of treatment and its alternatives
- the patient is informed of the expected benefits and potential material side-effects
- the patient is informed of any consequences of not having the treatment
- the patient is given a response to any questions he or she may have.

The Act identifies a capable patient as one who is able to understand information relevant to making the decision and is able to appreciate the reasonably foreseeable consequences of the decision. No age is specified for consent to health care as long as the above criteria are met. A person may be incapable with respect to giving consent for some treatments and capable with respect to others. Similarly, a person may be incapable with respect providing consent to a treatment at one time and capable at another time.

If the healthcare professional determines that a patient is not capable of providing valid consent, the patient must be informed of the finding of incapacity and the consequences of that finding. For example, an optometrist would inform the patient that the exam can't be completed, or that the patient will need to bring someone with them to consent to the completion of the exam and/or treatment. The Act contains a list of the persons who may give or refuse consent on behalf of the incapable patient, and the requirements for the person giving consent (e.g., they must be capable themselves, willing to assume the responsibility, etc.)

Health Care Consent Act, 1996

S.O. 1996, CHAPTER 2
(excerpt)

SCHEDULE A

Amended by: 1998, c. 26, s. 104; 2000, c. 9, ss. 31-48; 2002, c. 18, Sched. A, s. 10; 2004, c. 3, Sched. A, s. 84.

PART I
GENERAL

Purposes

1. The purposes of this Act are,

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and

(iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

(d) to promote communication and understanding between health practitioners and their patients or clients;

(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment,

admission to a care facility or personal assistance services. 1996, c. 2, Sched. A, s. 1.

Interpretation

2. (1) In this Act,

"attorney for personal care" means an attorney under a power of attorney for personal care given under the *Substitute Decisions Act, 1992*; ("procureur au soin de la personne")

"Board" means the Consent and Capacity Board; ("Commission")

"capable" means mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité")

"care facility" means,

(a) an approved charitable home for the aged, as defined in the *Charitable Institutions Act*,

(b) a home or joint home, as defined in the *Homes for the Aged and Rest Homes Act*,

(c) a nursing home, as defined in the *Nursing Homes Act*, or

(d) a facility prescribed by the regulations as a care facility; ("établissement de soins")

"community treatment plan" has the same meaning as in the *Mental Health Act*; ("plan de traitement en milieu communautaire")

"course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; ("série de traitements")

"evaluator" means, in the circumstances prescribed by the regulations, a person described in clause (a), (l), (m), (o), (p) or (q) of the definition of "health practitioner" in this subsection or a member of a category of persons prescribed by the regulations as evaluators; ("appréciateur")

"guardian of the person" means a guardian of the person appointed under the *Substitute Decisions Act, 1992*; ("tuteur à la personne")

"health practitioner" means,

(a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,

(b) a member of the College of Chiropodists of Ontario, including a member who is a podiatrist,

(c) a member of the College of Chiropractors of Ontario,

(d) a member of the College of Dental Hygienists of Ontario,

(e) a member of the Royal College of Dental Surgeons of Ontario,

(f) a member of the College of Denturists of Ontario,

(g) a member of the College of Dietitians of Ontario,

(h) a member of the College of Massage Therapists of Ontario,

(i) a member of the College of Medical Laboratory Technologists of Ontario,

(j) a member of the College of Medical Radiation Technologists of Ontario,

(k) a member of the College of Midwives of Ontario,

(l) a member of the College of Nurses of Ontario,

(m) a member of the College of Occupational Therapists of Ontario,

(n) a member of the College of Optometrists of Ontario,

(o) a member of the College of Physicians and Surgeons of Ontario,

(p) a member of the College of Physiotherapists of Ontario,

(q) a member of the College of Psychologists of Ontario,

(r) a member of the College of Respiratory Therapists of Ontario,

(s) a naturopath registered as a drugless therapist under the *Drugless Practitioners Act*, or

(t) a member of a category of persons prescribed by the regulations as health practitioners; ("praticien de la santé")

"hospital" means an institution as defined in the *Mental Hospitals Act*, a private hospital as defined in the *Private Hospitals Act* or a hospital as defined in the *Public Hospitals Act*; ("hôpital")

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning; ("incapable", "incapacité")

"mental disorder" has the same meaning as in the *Mental Health Act*; ("trouble mental")

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service; ("service d'aide personnelle")

"plan of treatment" means a plan that,

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")

"psychiatric facility" has the same meaning as in the *Mental Health Act*; ("établissement psychiatrique")

"recipient" means a person who is to be provided with one or more personal assistance services,

(a) in an approved charitable home for the aged, as defined in the *Charitable Institutions Act*,

(b) in a home or joint home, as defined in the *Homes for the Aged and Rest Homes Act*,

(c) in a nursing home, as defined in the *Nursing Homes Act*,

(d) in a place prescribed by the regulations in the circumstances prescribed by the regulations,

(e) under a program prescribed by the regulations in the circumstances prescribed by the regulations, or

(f) by a provider prescribed by the regulations in the circumstances prescribed by the regulations; ("bénéficiaire")

"regulations" means the regulations made under this Act; ("règlements")

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. (“traitement”) 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31.

Refusal of consent

(2) A reference in this Act to refusal of consent includes withdrawal of consent. 1996, c. 2, Sched. A, s. 2 (2).

Meaning of “excluded act”

3. (1) In this section,

“excluded act” means,

(a) anything described in clause (b) or (g) of the definition of “treatment” in subsection 2 (1), or

(b) anything described in clause (h) of the definition of “treatment” in subsection 2 (1) and prescribed by the regulations as an excluded act. 1996, c. 2, Sched. A, s. 3 (1).

Excluded act considered treatment

(2) If a health practitioner decides to proceed as if an excluded act were a treatment for the purpose of this Act, this Act and the regulations apply as if the excluded act were a treatment within the meaning of this Act. 1996, c. 2, Sched. A, s. 3 (2).

Capacity

4. (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).

Presumption of capacity

(2) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services. 1996, c. 2, Sched. A, s. 4 (2).

Exception

(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be. 1996, c. 2, Sched. A, s. 4 (3).

Wishes

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

Manner of expression

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).

Later wishes prevail

(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).

Research, sterilization, transplants

6. This Act does not affect the law relating to giving or refusing consent on another person's behalf to any of the following procedures:

1. A procedure whose primary purpose is research.

2. Sterilization that is not medically necessary for the protection of the person's health.

3. The removal of regenerative or non-regenerative tissue for implantation in another person's body. 1996, c. 2, Sched. A, s. 6.

Restraint, confinement

7. This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others. 1996, c. 2, Sched. A, s. 7.

PART II
TREATMENT

GENERAL

Application of Part

8. (1) Subject to section 3, this Part applies to treatment. 1996, c. 2, Sched. A, s. 8 (1).

Law not affected

(2) Subject to section 3, this Part does not affect the law relating to giving or refusing consent to anything not included in the definition of "treatment" in subsection 2 (1). 1996, c. 2, Sched. A, s. 8 (2).

Meaning of "substitute decision-maker"

9. In this Part,

"substitute decision-maker" means a person who is authorized under section 20 to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment. 1996, c. 2, Sched. A, s. 9.

CONSENT TO TREATMENT

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to the treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's decision, the health practitioner shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless the person has given consent. 1996, c. 2, Sched. A, s. 10 (2).

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.

3. The material risks of the treatment.

4. The material side effects of the treatment.

5. Alternative courses of action.

6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Express or implied

(4) Consent to treatment may be express or implied. 1996, c. 2, Sched. A, s. 11 (4).

Included consent

12. Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,

(a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and

(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered. 1996, c. 2, Sched. A, s. 12.

Plan of treatment

13. If a plan of treatment is to be proposed for a person, one health practitioner may, on behalf of all the health practitioners involved in the plan of treatment,

(a) propose the plan of treatment;

(b) determine the person's capacity with respect to the treatments referred to in the plan of treatment; and

(c) obtain a consent or refusal of consent in accordance with this Act,

(i) from the person, concerning the treatments with respect to which the person is found to be capable, and

(ii) from the person's substitute decision-maker, concerning the treatments with respect to which the person is found to be incapable. 1996, c. 2, Sched. A, s. 13.

Withdrawal of consent

14. A consent that has been given by or on behalf of the person for whom the treatment was proposed may be withdrawn at any time,

(a) by the person, if the person is capable with respect to the treatment at the time of the withdrawal;

(b) by the person's substitute decision-maker, if the person is incapable with respect to the treatment at the time of the withdrawal. 1996, c. 2, Sched. A, s. 14.

CAPACITY

Capacity depends on treatment

15. (1) A person may be incapable with respect to some treatments and capable with respect to others. 1996, c. 2, Sched. A, s. 15 (1).

Capacity depends on time

(2) A person may be incapable with respect to a treatment at one time and capable at another. 1996, c. 2, Sched. A, s. 15 (2).

Return of capacity

16. If, after consent to a treatment is given or refused on a person's behalf in accordance with this Act, the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the treatment governs. 1996, c. 2, Sched. A, s. 16.

Information

17. A health practitioner shall, in the circumstances and manner specified in guidelines established by the governing body of the health practitioner's profession, provide to persons found by the health practitioner to be incapable with respect to treatment such information about the consequences of the findings as is specified in the guidelines. 1996, c. 2, Sched. A, s. 17.

Treatment must not begin

18. (1) This section applies if,

(a) a health practitioner proposes a treatment for a person and finds that the person is incapable with respect to the treatment;

(b) before the treatment is begun, the health practitioner is informed that the person intends to apply, or has applied, to the Board for a review of the finding; and

(c) the application to the Board is not prohibited by subsection 32 (2). 1996, c. 2, Sched. A, s. 18 (1).

Same

(2) This section also applies if,

(a) a health practitioner proposes a treatment for a person and finds that the person is incapable with respect to the treatment;

(b) before the treatment is begun, the health practitioner is informed that,

(i) the incapable person intends to apply, or has applied, to the Board for appointment of a representative to give or refuse consent to the treatment on his or her behalf, or

(ii) another person intends to apply, or has applied, to the Board to be appointed as the representative of the incapable person to give or refuse consent to the treatment on his or her behalf; and

(c) the application to the Board is not prohibited by subsection 33 (3). 1996, c. 2, Sched. A, s. 18 (2).

Same

(3) In the circumstances described in subsections (1) and (2), the health practitioner shall not begin the treatment, and shall take reasonable steps to ensure that the treatment is not begun,

(a) until 48 hours have elapsed since the health practitioner was first informed of the intended application to the Board without an application being made;

(b) until the application to the Board has been withdrawn;

(c) until the Board has rendered a decision in the matter, if none of the parties to the application before the Board has informed the health practitioner that he or she intends to appeal the Board's decision; or

(d) if a party to the application before the Board has informed the health practitioner that he or she intends to appeal the Board's decision,

(i) until the period for commencing the appeal has elapsed without an appeal being commenced, or

(ii) until the appeal of the Board's decision has been finally disposed of. 1996, c. 2, Sched. A, s. 18 (3).

Emergency

(4) This section does not apply if the health practitioner is of the opinion that there is an emergency within the meaning of subsection 25 (1). 1996, c. 2, Sched. A, s. 18 (4).

Order authorizing treatment pending appeal

19. (1) If an appeal is taken from a Board or court decision that has the effect of authorizing a person to consent to a treatment, the treatment may be administered before the final disposition of the appeal, despite section 18, if the court to which the appeal is taken so orders and the consent is given. 1996, c. 2, Sched. A, s. 19 (1).

Criteria for order

(2) The court may make the order if it is satisfied,

(a) that,

(i) the treatment will or is likely to improve substantially the condition of the person to whom it is to be administered, and the person's condition will not or is not likely to improve without the treatment, or

(ii) the person's condition will or is likely to deteriorate substantially, or to deteriorate rapidly, without the treatment, and the treatment will or is likely to prevent the deterioration or to reduce substantially its extent or its rate;

(b) that the benefit the person is expected to obtain from the treatment outweighs the risk of harm to him or her;

(c) that the treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a) and (b); and

(d) that the person's condition makes it necessary to administer the treatment before the final disposition of the appeal. 1996, c. 2, Sched. A, s. 19 (2).

Consent

List of persons who may give or refuse consent

20. (1) If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.

2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.

3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.

4. The incapable person's spouse or partner.

5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.

6. A parent of the incapable person who has only a right of access.

7. A brother or sister of the incapable person.

8. Any other relative of the incapable person. 1996, c. 2, Sched. A, s. 20 (1).

Requirements

(2) A person described in subsection (1) may give or refuse consent only if he or she,

(a) is capable with respect to the treatment;

(b) is at least 16 years old, unless he or she is the incapable person's parent;

(c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;

(d) is available; and

(e) is willing to assume the responsibility of giving or refusing consent. 1996, c. 2, Sched. A, s. 20 (2).

Ranking

(3) A person described in a paragraph of subsection (1) may give or refuse consent only if no person described in an earlier paragraph meets the requirements of subsection (2). 1996, c. 2, Sched. A, s. 20 (3).

Same

(4) Despite subsection (3), a person described in a paragraph of subsection (1) who is present or has otherwise been contacted may give or refuse consent if he or she believes that no other person described in an earlier paragraph or the same paragraph exists, or that although such a person exists, the person is not a person described in paragraph 1, 2 or 3 and would not object to him or her making the decision. 1996, c. 2, Sched. A, s. 20 (4).

No person in subs. (1) to make decision

(5) If no person described in subsection (1) meets the requirements of subsection (2), the Public Guardian and Trustee shall make the decision to give or refuse consent. 1996, c. 2, Sched. A, s. 20 (5).

Conflict between persons in same paragraph

(6) If two or more persons who are described in the same paragraph of subsection (1) and who meet the requirements of subsection (2) disagree about whether to give or refuse consent, and if their claims rank ahead of all others, the Public Guardian and Trustee shall make the decision in their stead. 1996, c. 2, Sched. A, s. 20 (6).

Meaning of "spouse"

(7) Subject to subsection (8), two persons are spouses for the purpose of this section if,

(a) they are married to each other; or

(b) they are living in a conjugal relationship outside marriage and,

(i) have cohabited for at least one year,

(ii) are together the parents of a child, or

(iii) have together entered into a cohabitation agreement under section 53 of the *Family Law Act*. 1996, c. 2, Sched. A, s. 20 (7); 2004, c. 3, Sched. A, s. 84 (1-3).

Not spouse

(8) Two persons are not spouses for the purpose of this section if they are living separate and apart as a result of a breakdown of their relationship. 2004, c. 3, Sched. A, s. 84 (4).

Meaning of "partner"

(9) For the purpose of this section,

"partner" means,

(a) Repealed: 2004, c. 3, Sched. A, s. 84 (5).

(b) either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives. 2002, c. 18, Sched. A, s. 10; 2004, c. 3; Sched. A, s. 84 (5, 6).

Meaning of "relative"

(10) Two persons are relatives for the purpose of this section if they are related by blood, marriage or adoption. 1996, c. 2, Sched. A, s. 20 (10).

Meaning of "available"

(11) For the purpose of clause (2) (d), a person is available if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal. 1996, c. 2, Sched. A, s. 20 (11).

Principles for giving or refusing consent

21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests. 1996, c. 2, Sched. A, s. 21 (1).

Best interests

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the treatment is likely to,

i. improve the incapable person's condition or well-being,

ii. prevent the incapable person's condition or well-being from deteriorating, or

iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.

2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.

4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed. 1996, c. 2, Sched. A, s. 21 (2).

Information

22. (1) Before giving or refusing consent to a treatment on an incapable person's behalf, a substitute decision-maker is entitled to receive all the information required for an informed consent as described in subsection 11 (2). 1996, c. 2, Sched. A, s. 22.

Conflict

(2) Subsection (1) prevails despite anything to the contrary in the Personal Health Information Protection Act, 2004. 2004, c. 3, Sched. A, s. 84 (7).

Ancillary treatment

23. Authority to consent to a treatment on an incapable person's behalf includes authority to consent to another treatment that is necessary and ancillary to the treatment, even if the incapable person is capable with respect to the necessary and ancillary treatment. 1996, c. 2, Sched. A, s. 23.

Admission to hospital, etc.

24. (1) Subject to subsection (2), a substitute decision-maker who consents to a treatment on an incapable person's behalf may consent to the incapable person's admission to a hospital or psychiatric facility or to another health facility prescribed by the regulations, for the purpose of the treatment. 1996, c. 2, Sched. A, s. 24 (1).

Objection, psychiatric facility

(2) If the incapable person is 16 years old or older and objects to being admitted to a psychiatric facility for treatment of a mental disorder, consent to his or her admission may be given only by,

(a) his or her guardian of the person, if the guardian has authority to consent to the admission; or

(b) his or her attorney for personal care, if the power of attorney contains a provision authorizing the attorney to use force that is necessary and reasonable in the circumstances to admit the incapable person to the psychiatric facility and the provision is effective under subsection 50 (1) of the *Substitute Decisions Act, 1992*. 1996, c. 2, Sched. A, s. 24 (2).

Emergency treatment

Meaning of "emergency"

25. (1) For the purpose of this section and section 27, there is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm. 1996, c. 2, Sched. A, s. 25 (1).

Emergency treatment without consent: incapable person

(2) Despite section 10, a treatment may be administered without consent to a person who is incapable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment,

(a) there is an emergency; and

(b) the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm. 1996, c. 2, Sched. A, s. 25 (2).

Emergency treatment without consent: capable person

(3) Despite section 10, a treatment may be administered without consent to a person who is apparently capable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment,

(a) there is an emergency;

(b) the communication required in order for the person to give or refuse consent to the treatment cannot take place because of a language barrier or because the person has a disability that prevents the communication from taking place;

(c) steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means has been found;

(d) the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and

(e) there is no reason to believe that the person does not want the treatment. 1996, c. 2, Sched. A, s. 25 (3).

Examination without consent

(4) Despite section 10, an examination or diagnostic procedure that constitutes treatment may be conducted by a health practitioner without consent if,

(a) the examination or diagnostic procedure is reasonably necessary in order to determine whether there is an emergency; and

(b) in the opinion of the health practitioner,

(i) the person is incapable with respect to the examination or diagnostic procedure, or

(ii) clauses (3) (b) and (c) apply to the examination or diagnostic procedure. 1996, c. 2, Sched. A, s. 25 (4).

Record

(5) After administering a treatment in reliance on subsection (2) or (3), the health practitioner shall promptly note in the person's record the opinions held by the health practitioner that are required by the subsection on which he or she relied. 1996, c. 2, Sched. A, s. 25 (5).

Continuing treatment

(6) Treatment under subsection (2) may be continued only for as long as is reasonably necessary to find the incapable person's substitute decision-maker and to obtain from him or her a consent, or refusal of consent, to the continuation of the treatment. 1996, c. 2, Sched. A, s. 25 (6).

Same

(7) Treatment under subsection (3) may be continued only for as long as is reasonably necessary to find a practical means of enabling the communication to take place so that the person can give or refuse consent to the continuation of the treatment. 1996, c. 2, Sched. A, s. 25 (7).

Search

(8) When a treatment is begun under subsection (2) or (3), the health practitioner shall ensure that reasonable efforts are made for the purpose of finding the substitute decision-maker, or a means of enabling the communication to take place, as the case may be. 1996, c. 2, Sched. A, s. 25 (8).

Return of capacity

(9) If, after a treatment is begun under subsection (2), the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the continuation of the treatment governs. 1996, c. 2, Sched. A, s. 25 (9).

No treatment contrary to wishes

26. A health practitioner shall not administer a treatment under section 25 if the health practitioner has reasonable grounds to believe that the person, while capable and after attaining 16 years of age, expressed a wish applicable to the circumstances to refuse consent to the treatment. 1996, c. 2, Sched. A, s. 26.

Emergency treatment despite refusal

27. If consent to a treatment is refused on an incapable person's behalf by his or her substitute decision-maker, the treatment may be administered despite the refusal if, in the opinion of the health practitioner proposing the treatment,

(a) there is an emergency; and

(b) the substitute decision-maker did not comply with section 21. 1996, c. 2, Sched. A, s. 27.

Admission to hospital, etc.

28. The authority to administer a treatment to a person under section 25 or 27 includes authority to have the person admitted to a hospital or psychiatric facility for the purpose of the treatment, unless the person objects and the treatment is primarily treatment of a mental disorder. 1996, c. 2, Sched. A, s. 28.

Protection from liability

Apparently valid consent to treatment

29. (1) If a treatment is administered to a person with a consent that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for administering the treatment without consent. 1996, c. 2, Sched. A, s. 29 (1).

Apparently valid refusal of treatment

(2) If a treatment is not administered to a person because of a refusal that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for failing to administer the treatment. 1996, c. 2, Sched. A, s. 29 (2).

Apparently valid consent to withholding or withdrawal

(3) If a treatment is withheld or withdrawn in accordance with a plan of treatment and with a consent to the plan of treatment that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for withholding or withdrawing the treatment. 1996, c. 2, Sched. A, s. 29 (3).

Emergency: treatment administered

(4) A health practitioner who, in good faith, administers a treatment to a person under section 25 or 27 is not liable for administering the treatment without consent. 1996, c. 2, Sched. A, s. 29 (4).

Emergency: treatment not administered

(5) A health practitioner who, in good faith, refrains from administering a treatment in accordance with section 26 is not liable for failing to administer the treatment. 1996, c. 2, Sched. A, s. 29 (5).

Reliance on assertion

(6) If a person who gives or refuses consent to a treatment on an incapable person's behalf asserts that he or she,

(a) is a person described in subsection 20 (1) or clause 24 (2) (a) or (b) or an attorney for personal care described in clause 32 (2) (b);

(b) meets the requirement of clause 20 (2) (b) or (c); or

(c) holds the opinions required under subsection 20 (4),

a health practitioner is entitled to rely on the accuracy of the assertion, unless it is not reasonable to do so in the circumstances. 1996, c. 2, Sched. A, s. 29 (6).

Person making decision on another's behalf

30. A person who gives or refuses consent to a treatment on another person's behalf, acting in good faith and in accordance with this Act, is not liable for giving or refusing consent. 1996, c. 2, Sched. A, s. 30.

Admission to hospital, etc.

31. (1) Sections 29 and 30, except subsection 29 (4), apply, with necessary modifications, to admission of the incapable person to a hospital, psychiatric facility or other health facility referred to in section 24, for the purpose of treatment. 1996, c. 2, Sched. A, s. 31 (1).

Same

(2) A health practitioner who, in good faith, has a person admitted to a hospital or psychiatric facility under section 28 is not liable for having the person admitted without consent. 1996, c. 2, Sched. A, s. 31 (2).

Health Insurance Act

The Health Insurance Act contains provisions related to the Ontario Health Insurance Plan (OHIP) and creates practitioner review committees to adjudicate claims for OHIP payment.

There are many optometric services that are insured services under OHIP. The current OHIP Schedule of Benefits can be found in the Jurisprudence Resource Binder. Only uninsured services can be billed to the patient. The Ontario Association of Optometrists has developed a Suggested Schedule of Professional Fees for these uninsured services.

Optometrists may choose to ‘opt in’ or ‘opt out’ of billing OHIP directly for their services. If an optometrist ‘opts out’, the patient will receive the payment from OHIP and is then expected to pay the optometrist. The patient cannot be required to pay for the service until he or she has received the payment from OHIP. Regardless of whether an optometrist is billing OHIP directly (opt in) or receiving payment from patients after they have been sent the OHIP payment (opt out), extra billing is prohibited.

Health Insurance Act

R.S.O. 1990, CHAPTER H.6

(excerpts)

Consolidation Period: From December 15, 2009 to the e-Laws currency date.

Note: March 31, 2010 has been named by proclamation as the day on which the amendments made by 2007, c. 10, Sched. G, ss. 14, 23 (7), 31, 33 (4), 34 come into force.

Note: July 1, 2010 has been named by proclamation as the day on which the amendments made by 2007, c. 8, s. 209 come into force.
Last amendment: 2015, c. 20, Sched. 15, s. 1–14.

Definitions
1. In this Act,
"Appeal Board" means the Health Services Appeal and Review Board under the Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998; ("Commission d'appel")
"business day" means a day on which Canada Post ordinarily delivers lettermail; ("jour ouvrable")
"Deputy Minister" means the Deputy Minister of Health and Long-Term Care; ("sous-ministre")
"future cost of insured services" means the estimated total cost of the future insured services made necessary as the result of an injury that will probably be required by a patient after the date of settlement or, where there is no settlement, the first day of trial; ("coût futur des services assurés")
"General Manager" means the General Manager appointed under section 4; ("directeur général")
Note: On a day to be named by proclamation of the Lieutenant Governor, section 1 is amended by adding the following definition:
"general requisition number" means the unique identifying number issued by the General Manager to a practitioner or health facility to identify that a service rendered by another practitioner or health facility or by a physician, hospital or independent health facility was requested by the practitioner or health facility; ("numéro de demande général")
See: 2009, c. 26, ss. 11 (1), 27 (2).
"health card" means a document in a prescribed form issued by the General Manager; ("carte Santé")
"health facility" means an ambulance service, a medical laboratory and any other facility prescribed by the regulations as a health facility for the purposes of this Act; ("établissement de santé")
Note: On a day to be named by proclamation of the Lieutenant Governor, section 1 is amended by adding the following definition:

“independent health facility” means an independent health facility within the meaning of the Independent Health Facilities Act; (“établissement de santé autonome”)
See: 2009, c. 26, ss. 11 (1), 27 (2).
“insured person” means a person who is entitled to insured services under this Act and the regulations; (“assuré”)
“insured services” means services that are determined under section 11.2 to be insured services; (“services assurés”)
“joint committee” means the Joint Committee on the Schedule of Benefits established under subsection 5 (1); (“comité mixte”)
“Minister” means the Minister of Health and Long-Term Care; (“ministre”)
“Ministry” means the Ministry of Health and Long-Term Care; (“ministère”)
“past cost of insured services” means the total cost of the insured services made necessary as the result of an injury and provided to a patient up to and including the date of settlement or, where there is no settlement, the first day of trial; (“coût antérieur des services assurés”)
“payment committee” means the Physician Services Payment Committee established under subsection 5.4 (1); (“comité de paiement”)
“payment correction list” means the list of circumstances described in subsection 18 (2) for which payments are subject to correction; (“liste de rectification au titre des paiements”)
“physician” means a legally qualified medical practitioner lawfully entitled to practise medicine in the place where medical services are rendered by the physician; (“médecin”)
“Plan” means the Ontario Health Insurance Plan referred to in section 10; (“Régime”)
“practitioner” means a person other than a physician who is lawfully entitled to render insured services in the place where they are rendered; (“praticien”)
“prescribed” means prescribed by the regulations; (“prescrit”)
“regulations” means the regulations made under this Act; (“règlements”)
“resident” means a resident as defined in the regulations and the verb “reside” has a corresponding meaning; (“résident”)
“Review Board” means the Physician Payment Review Board established under subsection 5.1 (1); (“Commission de révision”)
“schedule of benefits” means the schedule of benefits as defined by the regulations. (“liste des prestations”) R.S.O. 1990, c. H.6, s. 1; 1993, c. 2, s. 12; 1993, c. 32, s. 2 (1); 1994, c. 17, s. 68; 1996, c. 1, Sched. H, s. 1 (2); 1998, c. 18, Sched. G, s. 54 (1); 2006, c. 19, Sched. L, s. 11 (2, 4); 2007, c. 10, Sched. G, s. 1; 2009, c. 33, Sched. 18, ss. 11 (1), 17 (2).

Ontario Health Insurance Plan

Ontario Health Insurance Plan continued
10. The Ontario Health Insurance Plan is continued for the purpose of providing for insurance against the costs of insured services on a non-profit basis on uniform terms and conditions available to all residents of Ontario, in accordance with this Act, and providing other health benefits related thereto. R.S.O. 1990, c. H.6, s. 10.

Right to insurance
11. (1) Every person who is a resident of Ontario is entitled to become an insured person upon application therefor to the General Manager in accordance with this Act and the regulations. R.S.O. 1990, c. H.6, s. 11 (1).

Establishing entitlement
(2) It is the responsibility of every person to establish his or her entitlement to be, or to continue to be, an insured person. 1994, c. 17, s. 70.

Military families
(2.1) Where an application under subsection (1) is made with respect to a spouse or dependant of a member of the Canadian Forces, he or she is exempt from any waiting period that would otherwise apply. 2007, c. 16, Sched. B, s. 1.

Change in information
(3) It is the responsibility of every person who has been registered as an insured person to report to the General Manager, within 30 days of its occurrence, every change in the information that was reported to the General Manager for the purposes of establishing his or her entitlement to be or continue to be an insured person. 2007, c. 10, Sched. C, s. 2.

Health card
11.1 (1) A health card remains the property of the Minister at all times.

Taking possession of card
(2) A prescribed person may take possession of a health card that is surrendered to him or her voluntarily.

Return to General Manager
(3) On taking possession of a health card under subsection (2), the person shall return it to the General Manager as soon as possible.

Protection from liability
(4) No proceeding for taking possession of a health card shall be commenced against a person who does so in accordance with subsection (2). 1993, c. 32, s. 2 (4).

Insured services
11.2 (1) The following services are insured services for the purposes of the Act:
1. Prescribed services of hospitals and health facilities rendered under such conditions and limitations as may be prescribed.
2. Prescribed medically necessary services rendered by physicians under such conditions and limitations as may be prescribed.
3. Prescribed health care services rendered by prescribed practitioners under such conditions and limitations as may be prescribed. 1996, c. 1, Sched. H, s. 8.

Exceptions
(2) Despite subsection (1), services that a person is entitled to under the insurance plan established under the Workplace Safety and Insurance Act, 1997 or under the Homes for Special Care Act or under any Act of the Parliament of Canada except the Canada Health Act are not insured services. 1996, c. 1, Sched. H, s. 8; 1997, c. 16, s. 7.

Restrictions
(3) Such services as may be prescribed are insured services only if they are provided in or by designated hospitals or health facilities.

Same
(4) Such services as may be prescribed are insured services only if they are provided to insured persons in prescribed age groups.

Same
(5) Such services as may be prescribed are not insured services when they are provided to insured persons in prescribed age groups. 1996, c. 1, Sched. H, s. 8.

Entitlement to insured services
12. (1) Every insured person is entitled to payment to himself or herself or on his or her behalf for, or to be otherwise provided with, insured services in the amounts and subject to such conditions and co-payments, if any, as are prescribed. R.S.O. 1990, c. H.6, s. 12.
(2), (3) Repealed: 2007, c. 10, Sched. G, s. 4.

Choice of physician or practitioner
13. This Act shall not be administered or construed to affect the right of an insured person to choose his or her own physician or practitioner, and does not impose any obligation upon any physician or practitioner to treat an insured person. R.S.O. 1990, c. H.6, s. 13.

Other insurance prohibited
14. (1) Every contract of insurance, other than insurance provided under section 268 of the Insurance Act, for the payment of or reimbursement or indemnification for all or any part of the cost of any insured services other than,
(a) any part of the cost of hospital, ambulance and nursing home services that is not paid by the Plan;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause (a) is amended by the Statutes of Ontario, 2007, chapter 8, section 209 by striking out “nursing home services” and substituting “long-term care home services”. See: 2007, c. 8, ss. 209, 232 (2).

(b) compensation for loss of time from usual or normal activities because of disability requiring insured services;
(c) any part of the cost that is not paid by the Plan for such other services as may be prescribed when they are performed by such classes of persons or in such classes of facilities as may be prescribed,
performed in Ontario for any person eligible to become an insured person under this Act, is void and of no effect in so far as it makes provision for insuring against the costs payable by the Plan and no person shall enter into or renew such a contract. R.S.O. 1990, c. H.6, s. 14 (1); 1996, c. 1, Sched. H, s. 10.

Resident not to benefit from prohibited insurance
(2) A resident shall not accept or receive any benefit under any contract of insurance prohibited under subsection (1) whereby the resident or his or her

dependants may be provided with or reimbursed or indemnified for all or any part of the costs of, or costs directly related to the provision of any insured service. R.S.O. 1990, c. H.6, s. 14 (2).

Exceptions
(3) Subsections (1) and (2) do not apply to a contract of insurance entered into by a resident whose principal employment is in the United States of America and who is entitled to enter into the contract by virtue of his or her employment. R.S.O. 1990, c. H.6, s. 14 (3).

Idem
(4) Where payment is made to or on behalf of an insured person under a contract or agreement referred to in subsection (3) and such payment is less than would have been made under this Act and the regulations for the same insured services, the General Manager may pay to or on behalf of the insured person the difference between the amount paid under the contract or agreement and the amount established by the regulations for the insured services for which payment was made under the contract or agreement. R.S.O. 1990, c. H.6, s. 14 (4).

Exception
(5) Subsections (1) and (2) do not apply during the period that a person who is a resident must wait to be registered as an insured person. 2000, c. 26, Sched. H, s. 1 (5); 2006, c. 19, Sched. L, s. 3 (5).

Billing – practitioners
15.1 (1) A designated practitioner shall submit all of his or her accounts for the performance of insured services directly to the Plan in accordance with and subject to the requirements of this Act and the regulations, unless an agreement under subsection 2 (2) provides otherwise. 2004, c. 5, s. 36.

Same – non-designated
(2) A non-designated practitioner shall submit directly to the Plan that part of his or her account for insured services rendered to an insured person that is payable by the Plan, unless an agreement under subsection 2 (2) provides otherwise. 2004, c. 5, s. 36.

Requirements where Plan billed
(3) Where a practitioner submits his or her accounts directly to the Plan under this section,
(a) payment shall be made,
(i) directly to the practitioner, or
(ii) as the practitioner directs in accordance with section 16.1;
(b) in the case of a designated practitioner, the payment by the Plan for the insured services performed constitutes payment in full of the account; and

(c) in the case of a non-designated practitioner, the payment by the Plan for that part of his or her account for an insured service rendered to an insured person that is payable by the Plan constitutes payment in full of that part of the account. 2004, c. 5, s. 36.

Where s. 2 (2) applies

(4) Where an account is submitted to the Plan in accordance with subsection 2 (2) with respect to insured services rendered to an insured person, the payment by the Plan constitutes payment in full of the account. 2004, c. 5, s. 36.

Interpretation

(5) In this section,

"designated practitioner", "non-designated practitioner" and "practitioner" have the same meanings as in Part II of the Commitment to the Future of Medicare Act, 2004. 2004, c. 5, s. 36.

Transitional

15.2 (1) The following rules apply with respect to a physician or designated practitioner to whom subsection 11 (7) of the Commitment to the Future of Medicare Act, 2004 applies:

1. Sections 15 and 15.1 do not apply to him or her.
2. Subsections 15 (5), 16 (5), 16.1 (2), 17 (2), 25 (2) to (9), and 27.2 (3) and (4), as applicable, as they existed immediately before their repeal by the Commitment to the Future of Medicare Act, 2004 continue to apply to the physician or designated practitioner, as the case may be, as if they had not been repealed, except in respect of any prescribed accounts or classes of accounts, and subject to any prescribed circumstances or conditions.
3. Where, under subsection 27.2 (3), the physician or designated practitioner is required to temporarily submit his or her accounts directly to the Plan, the submission of the accounts is not a deemed election for the purposes of subsection 11 (6) of the Commitment to the Future of Medicare Act, 2004, but subsection 10 (3) of that Act applies to him or her during the time that he or she is temporarily required to submit accounts directly to the Plan.
4. All other applicable provisions of this Act apply to the physician or designated practitioner. 2004, c. 5, s. 36.

Same

(2) Where a designated practitioner to whom section 11 of the Commitment to the Future of Medicare Act, 2004 applies submits his or her accounts for the rendering of insured services to insured persons directly to the Plan, subsections 25 (2) to (9) of this Act, as they existed before their repeal, apply to him or her with respect to accounts submitted before he or she commenced submitting his or her accounts directly to the Plan. 2004, c. 5, s. 36; 2007, c. 10, Sched. G, s. 5 (1).

Same

(2.1) Despite paragraph 2 of subsection (1), subsections 25 (3), (4), (5), (6) and (8), as they existed immediately before their repeal by the Commitment to the

Future of Medicare Act, 2004 cease to apply to physicians on the day that this subsection comes into force. 2007, c. 10, Sched. G, s. 5 (2).

Interpretation
(3) In this section,
"physician" and "designated practitioner" mean a physician or designated practitioner within the meaning of Part II of the Commitment to the Future of Medicare Act, 2004. 2004, c. 5, s. 36.

Billing numbers
16. (1) An account or claim submitted in the name of a physician or practitioner in conjunction with the billing number issued to the physician or practitioner, and any payment made pursuant to the account or claim is deemed to have been,
(a) submitted personally by the physician or practitioner;
(b) paid to the physician or practitioner personally;
(c) received by the physician or practitioner personally; and
(d) made by and submitted with the consent and knowledge of the physician or practitioner. 2004, c. 5, s. 36.

Health facilities
(2) Subsection (1) applies with necessary modifications to health facilities. 2004, c. 5, s. 36.

Applies despite direction
(3) This section applies despite a direction given pursuant to section 16.1. 2004, c. 5, s. 36.

Exception
(4) This section does not apply to an account, claim or payment in the circumstances and on the conditions prescribed in the regulations. 2004, c. 5, s. 36.

Definition
(5) In this section,
"billing number" means the unique identifying number issued by the General Manager to a physician, practitioner or health facility for the purpose of identifying the accounts or claims for insured services rendered by that physician, practitioner or health facility. 2004, c. 5, s. 36.

Direction to make payments to entity
16.1 (1) A physician or a practitioner may direct that payments for services performed by the physician or practitioner and to which the physician or practitioner is lawfully entitled may be directed to such person or entity as may be prescribed and in such circumstances and on such conditions as may be prescribed, including such requirements and other matters with respect to directions as may be prescribed. 2000, c. 42, Sched., s. 19.

(2) Repealed: 2004, c. 5, s. 37.

Person or entity not entitled
(3) The entitlement to payment for services performed by a physician or a practitioner is that of the physician or practitioner and not that of the person or entity to which the physician or practitioner has directed that such a payment be made. 2000, c. 42, Sched., s. 19.

Repayment to Plan
(4) Where payment is made by the Plan to a person or entity pursuant to subsection (1), any money owing to the Plan by the physician or the practitioner may be recovered from the physician or practitioner personally. 2000, c. 42, Sched., s. 19.

Interpretation
(5) A reference in this Act or the regulations to a payment to a physician or a practitioner where the reference relates to a payment for services performed by the physician or practitioner shall be deemed to include a payment made to a person or entity pursuant to a direction made under this section. 2000, c. 42, Sched., s. 19.

Keeping and inspection of records
(6) Section 37.1 applies with necessary modifications to a person or entity to whom payment is made pursuant to a direction by a physician or practitioner and,
(a) in the case of a direction by a practitioner, subsections 40 (3) and (4) and sections 40.1 and 40.2 apply with necessary modifications to an inspection of the records required to be kept; and
(b) in the case of a direction by a physician, subsections 37 (5) to (7) apply with necessary modifications in respect of the records required to be kept. 2007, c. 10, Sched. G, s. 6.

Accounts for insured services
17. (1) Physicians, practitioners and health facilities shall prepare accounts for their insured services in such form as the General Manager may require. The accounts must meet the prescribed requirements. 1996, c. 1, Sched. H, s. 11.
(2) Repealed: 2004, c. 5, s. 38.

Time for submitting
(3) The physician, practitioner, health facility or, in the case of a patient who is billed directly, the patient must submit an account for an insured service to the General Manager within such time after the service is performed as may be prescribed. When submitted, the account must be in the required form and meet the prescribed requirements. 1996, c. 1, Sched. H, s. 11; 2000, c. 26, Sched. H, s. 1 (6).

Fees payable for insured services
17.1 (1) A physician or practitioner who submits an account to the General Manager in accordance with this Act for insured services provided by the physician or practitioner is entitled to be paid the fee determined under this section. 2007, c. 10, Sched. G, s. 7.

Same
(2) An insured person who submits an account to the General Manager in accordance with this Act for insured services provided by a physician or practitioner to the insured person is entitled to be paid the fee determined under this section. 2007, c. 10, Sched. G, s. 7.

Amount
(3) The basic fee payable for an insured service is the amount set out in the regulations. The amount may differ for different classes of physician or practitioner. 1996, c. 1, Sched. H, s. 12.

Same
(4) The regulations may provide that the basic fee for an insured service is nil. 1996, c. 1, Sched. H, s. 12.

Adjustment of amount
(5) The basic fee payable for an insured service performed by a physician or practitioner may be increased or decreased as provided in the regulations based upon one or more of the following factors:
1. The professional specialization of the physician or practitioner.
2. The relevant professional experience of the physician or practitioner.
3. The frequency with which the physician or practitioner provides the insured service.
4. The geographic area in which the insured service is provided.
5. The setting in which the insured service is provided.
6. The period of time when the insured service is provided.
7. Such other factors as may be prescribed. 1996, c. 1, Sched. H, s. 12.

Threshold amount
(6) If the total amount payable for one or more prescribed insured services provided by a physician or practitioner during a prescribed period equals or exceeds a prescribed amount, the fee payable for an insured service may be increased or decreased in accordance with the regulations. The fee payable may be reduced to nil. 1996, c. 1, Sched. H, s. 12.

Same
(7) A change made under subsection (6) in the fee payable for an insured service is imposed in addition to any change made under subsection (5) in the basic fee payable. 1996, c. 1, Sched. H, s. 12.
(8) Repealed: 2007, c. 10, Sched. G, s. 7.

18.1 (1), (2) Repealed: 2007, c. 10, Sched. G, s. 13 (1).

Review by committee, practitioner
(3) A practitioner may request that a decision of the General Manager under subsection 18 (2) or (5) be reviewed by the applicable practitioner review committee. 1996, c. 1, Sched. H, s. 13.

Same
(4) The practitioner may request that the review be performed by a single member of the practitioner review committee,
(a) if the amount of money in dispute is less than such amount as may be prescribed; or
(b) if the General Manager consents to a review by a single committee member. 1996, c. 1, Sched. H, s. 13.

Time for request
(5) A request for a review must be made within 60 days after the practitioner receives notice of the decision of the General Manager and must be accompanied by the prescribed application fee for the type of review requested. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (2).

Expedited review
(6) The following rules apply with respect to a review by a single committee member:
1. The review must begin promptly after the request is made and must be conducted expeditiously.
2. The committee member may give any direction that the applicable committee is authorized under subsection (10) to give. If the review results from a request made under clause (4) (a), the direction may provide for payment or reimbursement of an amount greater than the prescribed amount referred to in that clause.
3. In such circumstances as the committee member considers appropriate, he or she may recommend that the General Manager consider requesting a review under section 39.1 and may give the General Manager such information as the committee member considers appropriate.
4. Following the review, the committee member shall promptly give notice to the practitioner of his or her direction under paragraph 2. The committee member is not required to give written reasons for the direction. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (1, 2); 2007, c. 10, Sched. G, s. 13 (3, 4).

Same, reconsideration
(7) A person aggrieved by the direction given by the single committee member may request the applicable practitioner review committee to reconsider the matter. 2007, c. 10, Sched. G, s. 13 (5).

Request for reconsideration
(8) A request for reconsideration must be made within 30 days after the practitioner receives notice of the single committee member's direction, and must be accompanied by the prescribed application fee. 2002, c. 18, Sched. I, s. 8 (4); 2007, c. 10, Sched. G, s. 13 (6).

Procedural directions
(9) During a review or reconsideration, the applicable committee or a single committee member, as the case may be, may require the practitioner to take such steps by such time as the committee or member may determine. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (7).

Direction by committee
(10) Following the review or following its reconsideration of a review by a single committee member, the practitioner review committee may give a direction,
(a) that the decision of the General Manager be confirmed;
(b) that the General Manager make a payment in accordance with the submitted account;
(c) that the General Manager pay a reduced amount, as calculated by the General Manager in accordance with the direction; or
(d) that the practitioner reimburse the Plan in the amount calculated by the General Manager in accordance with the direction. 2002, c. 18, Sched. I, s. 8 (5); 2007, c. 10, Sched. G, s. 13 (8, 9).

Recommendation of further review
(11) Following the review or following its reconsideration of a review by a single committee member, the practitioner review committee may recommend in such circumstances as it considers appropriate that the General Manager consider requesting a review under section 39.1 and may give the General Manager such information as it considers appropriate. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (10).

Notice
(12) The applicable committee shall serve the persons affected by a direction given under subsection (10) with a notice stating that the practitioner may appeal it to the Appeal Board. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (11).

Reasons for direction
(13) Upon request, the applicable committee shall give the persons affected by its direction written reasons for it. 1996, c. 1, Sched. H, s. 13.

Interest
(14) If, as a result of a direction, an amount is payable by or to a practitioner, interest is also payable on the amount. Interest is calculated in the prescribed manner and is payable from the date determined in the prescribed manner. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (12).

Additional payment
(15) The practitioner shall pay an additional amount for the cost of the review and for the cost of any reconsideration of a review,
(a) if a decision of the General Manager refusing to pay an account for services provided by the practitioner is confirmed;
(b) if, as a result of a direction, the practitioner is required to reimburse the Plan; or
(c) if the General Manager is required to pay him or her less than the amount of the account submitted for the insured services. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (13).

Same
(16) The additional amount under subsection (15) shall be determined in the prescribed manner. 1996, c. 1, Sched. H, s. 13.

Refund of fee
(17) The General Manager shall refund any portion of the application fee paid by the practitioner that remains after the additional amount, if any, under subsection (15) is paid. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (14).

Publication of details
(18) The General Manager may make public the following information relating to the matter under review:
1. The name and specialty, if any, of the practitioner.
2. The municipality or geographic area in which the practitioner practised his or her profession when the services giving rise to the direction of the applicable committee were provided.
3. The municipality or geographic area in which the practitioner practises his or her profession when the information is made public.
4. A description of the situation under review. The description must not identify, or enable a person to identify, a patient.
5. The amount, if any, that the practitioner is required to pay to the Plan.
6. Such other information as may be prescribed. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (6); 2007, c. 10, Sched. G, s. 13 (15).

No appeal
(19) The decision of the General Manager to make information public under subsection (18) is final and shall not be appealed to the Appeal Board or the Divisional Court. 1996, c. 1, Sched. H, s. 13.

Restriction
(20) The General Manager shall not make the information public until any appeal of a related direction given under subsection (10) is finally determined. 1996, c. 1, Sched. H, s. 13.

Same
(21) The General Manager shall not make the information public if the matter is reviewed by a single committee member and no reconsideration of the review is requested under subsection (7). 1996, c. 1, Sched. H, s. 13.

Review
18.2 (1) The General Manager may request the Medical Review Committee to review the provision of a service by a physician, practitioner or health facility when the service was provided at the request of another physician and the General Manager is of the opinion that the service was not medically necessary. 2002, c. 18, Sched. I, s. 8 (7).

Direction to repay
(2) If directed to do so by the Medical Review Committee, the physician who requested the provision of the service shall reimburse the Plan,
(a) in the amount paid by the Plan to the physician or practitioner for the service;
(b) in the amount paid by the Plan to the health facility, if the health facility submitted an account to the General Manager for the service;
(c) in the amount of the facility fee paid to the health facility under the Independent Health Facilities Act; or
(d) in the case of a health facility other than one referred to in clause (b) or (c), in the amount otherwise payable by the Plan to a health facility that submits accounts to the General Manager for such services. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (8).

Same
(3) Subsections 18.1 (14) to (16) and (18) to (20) apply following a direction. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (9).

Notice
(4) The Committee shall serve the physician with a notice stating that he or she may appeal the direction to the Appeal Board. 1996, c. 1, Sched. H, s. 13.

Reasons for direction
(5) Upon request, the Committee shall give the physician written reasons for the direction. 1996, c. 1, Sched. H, s. 13.

Appeal
(6) Section 20 applies, with necessary modifications, with respect to an appeal to the Appeal Board. 1996, c. 1, Sched. H, s. 13.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 18.2 is repealed by the Statutes of Ontario, 2007, chapter 10, Schedule G, section 14 and the following substituted:

Review of referrals
18.2 (1) If the General Manager is of the opinion that a service performed by a physician, practitioner, health facility or independent health facility is not medically necessary, and that service was requested by another physician, the General Manager may give a notice to the Review Board requesting it to hold a hearing to review the provision of the service that was requested. 2007, c. 10, Sched. G, s. 14.

Where finding that not necessary
(2) If the Review Board finds that the requested service was not medically necessary, the physician who requested the provision of the service shall pay to the Plan the amount paid by the Plan to the physician, practitioner, health facility or independent health facility who performed the service, and the General Manager may require the amount owing be paid through any method permitted under this Act. 2007, c. 10, Sched. G, s. 14.
See: 2007, c. 10, Sched. G, ss. 14, 36 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by adding the following section:

Practitioners and health facilities
18.2.1 If the General Manager is of the opinion that a service performed by a physician, practitioner, health facility, hospital or independent health facility is not medically necessary, or is rendered in other prescribed circumstances, and that service was requested by a practitioner or health facility,
(a) the practitioner or health facility who requested the provision of the service is liable to pay to the Plan the amount paid by the Plan to the physician, practitioner, health facility, hospital or independent health facility that performed the service; and
(b) the General Manager may make a direction requiring the amount owing to be paid to the Plan, and recover the amount through any method permitted under this Act. 2009, c. 26, s. 11 (3).
See: 2009, c. 26, ss. 11 (3), 27 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, section 14 by adding the following section:

Physician payment review process
18.3 (1) Where under this Act a physician or the General Manager gives notice to the Review Board requesting it to hold a hearing, the matter shall be dealt with

by the Review Board in accordance with this Act and Schedule 1. 2007, c. 10, Sched. G, s. 14.

Same
(2) A review panel of the Review Board may determine all issues relating to payments for insured services and may make orders for payments from the Plan that are authorized under this Act. 2007, c. 10, Sched. G, s. 14.
See: 2007, c. 10, Sched. G, ss. 14, 36 (2).

When services not medically necessary
19. (1) Where there is a dispute regarding a decision by the General Manager that an insured person is not entitled to an insured service in a hospital or health facility because such service is not medically necessary, the General Manager, upon receiving notice of such dispute, shall refer the matter to the Medical Eligibility Committee.

Medical Eligibility Committee to consider
(2) The Medical Eligibility Committee shall consider the facts relevant to the disputed decision, including any medical records and reports about the insured person and, when considered necessary by the Committee, interviewing the insured person and discussing the matter with the person and his or her physician.

Recommendations
(3) After giving consideration to the matter, the Medical Eligibility Committee shall recommend to the General Manager either that he or she pay or refuse to pay, according to the findings of the Committee, the sum or sums claimed by the insured person to be payable to the person or on his or her behalf, as the case may be, and that the General Manager approve or refuse to approve, in accordance with the recommendations of the Committee, the provision of the insured service or services that are in dispute and, subject to sections 20 to 24, the General Manager shall carry out the recommendations of the Committee. R.S.O. 1990, c. H.6, s. 19.

19.1 Repealed: 2004, c. 5, s. 39.

Refusal of claims, entitlement
19.2 (1) The General Manager may refuse a claim for payment for insured services if, in the opinion of the General Manager, the person who received the services was not an insured person at the time the services were rendered.

Direction by Appeal Board to pay
(2) The Appeal Board may direct the General Manager to pay any claims he or she refused to pay under subsection (1) if, after a hearing, the Appeal Board

determines that the person to whom the insured services were rendered was an insured person at the time the services were rendered. 1994, c. 17, s. 71.

Appeal to Appeal Board
20. (1) The following persons may appeal the following matters to the Appeal Board:
1. A person who has applied to become or continue to be an insured person may appeal a decision of the General Manager refusing the application.
2. An insured person who has made a claim for payment for insured services may appeal a decision of the General Manager refusing the claim or reducing the amount so claimed to an amount less than the amount payable by the Plan.
3. Repealed: 2007, c. 10, Sched. G, s. 15.
4. The affected practitioner may appeal a direction of a practitioner review committee under subsection 18.1 (10) but not a direction of a single committee member under paragraph 2 of subsection 18.1 (6). 1996, c. 1, Sched. H, s. 15; 2002, c. 18, Sched. I, s. 8 (10, 11); 2007, c. 10, Sched. G, s. 15.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by adding the following paragraph:
5. A practitioner or health facility required by the General Manager to make a payment under section 18.2.1 may appeal the direction.
See: 2009, c. 26, ss. 11 (4), 27 (2).

Notice of appeal
(2) The appellant shall file a notice of appeal within 15 days after receiving notice of the decision of the General Manager or the direction of the applicable committee. 1996, c. 1, Sched. H, s. 15.

Powers of Appeal Board
21. (1) If a person requires a hearing, the Appeal Board shall appoint a time for and hold the hearing and may, by order, direct the General Manager to take such action as the Appeal Board considers the General Manager should take in accordance with this Act and the regulations. 2002, c. 18, Sched. I, s. 8 (12).

Same
(1.0.1) For the purposes of making an order under subsection (1), the Appeal Board may amend a direction of the General Manager or a practitioner review committee and shall do so in accordance with this Act and the regulations. 2002, c. 18, Sched. I, s. 8 (12); 2007, c. 10, Sched. G, s. 16 (1).

Security for payment
(1.1) The Appeal Board may make an order at any time directing a practitioner to provide security for payment of all or part of an amount determined by the General Manager or a practitioner review committee to be owing to the Plan and may impose such conditions as the Appeal Board considers appropriate. 1996, c. 1, Sched. H, s. 16; 2007, c. 10, Sched. G, s. 16 (2).

Same
(1.2) The Appeal Board shall make an order for security for payment in such circumstances as may be prescribed. The security must meet such requirements as may be prescribed. 1996, c. 1, Sched. H, s. 16.

Extension of time for hearing
(2) The Appeal Board may extend the time for the giving of notice by a person requiring a hearing under this section, either before or after expiration of such time, where it is satisfied that there are apparent grounds for granting relief to the claimant pursuant to a hearing and that there are reasonable grounds for applying for the extension, and the Appeal Board may give such directions as it considers proper consequent upon the extension. R.S.O. 1990, c. H.6, s. 21 (2).

Parties
22. (1) The General Manager is a party to all proceedings before the Appeal Board. 1996, c. 1, Sched. H, s. 17.
(2) Repealed: 2007, c. 10, Sched. G, s. 17.

Same
(3) The practitioner review committee and the practitioner are parties to an appeal from a direction of the committee. 1996, c. 1, Sched. H, s. 17.

Same
(4) The Appeal Board may add such other parties to a proceeding as it considers appropriate. 1996, c. 1, Sched. H, s. 17.

Evidence

Examination of documentary evidence
23. (1) A person who is a party to proceedings before the Appeal Board shall be afforded an opportunity to examine before the hearing any written or documentary evidence that will be produced or any report the contents of which will be given in evidence at the hearing. R.S.O. 1990, c. H.6, s. 23 (1).

Board members not to have investigated prior to hearing
(2) Members of the Appeal Board holding a hearing shall not have taken part, before the hearing, in any investigation or consideration of the subject-matter of the hearing and shall not communicate directly or indirectly in relation to the subject-matter of the hearing with any person or with any party or representative of the party except upon notice to and with opportunity for all parties to participate, but the Appeal Board may seek legal advice from an adviser independent from the parties and in such case the nature of the advice should be made known to the parties in order that they may make submissions as to the law. R.S.O. 1990, c. H.6, s. 23 (2).

Recording evidence
(3) The oral evidence taken before the Appeal Board at a hearing shall be recorded and, if so required, copies of a transcript thereof shall be furnished upon the same terms as in the Superior Court of Justice. R.S.O. 1990, c. H.6, s. 23 (3); 2006, c. 19, Sched. C, s. 1 (1).

Findings of fact
(4) The findings of fact of the Appeal Board pursuant to a hearing shall be based exclusively on evidence admissible or matters that may be noticed under section 15 or 16 of the Statutory Powers Procedure Act. R.S.O. 1990, c. H.6, s. 23 (4).
(5) Repealed: 1998, c. 18, Sched. G, s. 54 (5).

Release of documents, etc.
(6) Documents and things put in evidence at the hearing shall, upon the request of the person who produced them, be released to the person by the Appeal Board within a reasonable time after the matter in issue has been finally determined. R.S.O. 1990, c. H.6, s. 23 (6).

Appeal to Divisional Court
24. (1) Any party to the proceedings before the Appeal Board under this Act may appeal from its decision or order to the Divisional Court in accordance with the rules of court. R.S.O. 1990, c. H.6, s. 24 (1); 1998, c. 18, Sched. G, s. 54 (6).

Record to be filed in court
(2) Where any party appeals from a decision or order of the Appeal Board, the Appeal Board shall forthwith file in the Divisional Court the record of the proceedings before it in which the decision was made, which, together with the transcript of evidence if it is not part of the Appeal Board's record, shall constitute the record in the appeal.

Minister to be heard
(3) The Minister is entitled to be heard by counsel or otherwise upon the argument of an appeal under this section.

Powers of court on appeal
(4) An appeal under this section may be made on questions of law or fact or both and the court may affirm or may rescind the decision of the Appeal Board and may exercise all powers of the Appeal Board to direct the General Manager to take any action which the Appeal Board may direct the General Manager to take and as the court considers proper and for such purposes the court may substitute its opinion for that of the General Manager or of the Appeal Board, or the court may refer the matter back to the Appeal Board for rehearing, in whole or in part, in accordance with such directions as the court considers proper. R.S.O. 1990, c. H.6, s. 24 (2-4).

Security for payment
(5) Subsections 21 (1.1) and (1.2) apply, with necessary modifications, with respect to the court. 1996, c. 1, Sched. H, s. 18.

Furnishing reasons to professional governing body
25. (1) Where a decision of the General Manager to refuse or reduce a payment or to require and recover reimbursement of any overpayment of any amount paid by the Plan on any of the grounds referred to in paragraphs 1 to 7 of subsection 18 (2) has become final, the General Manager shall furnish the Minister and the governing body of the profession of which the practitioner rendering the services is a member with a copy of the decision and the reasons therefor, and in all other cases the General Manager may furnish such governing body with a copy of the decision and the reasons therefor. R.S.O. 1990, c. H.6, s. 25 (1); 2002, c. 18, Sched. I, s. 8 (13); 2007, c. 10, Sched. G, s. 18.
(2) Repealed: 2004, c. 5, s. 40 (1).
(3) Repealed: 2004, c. 5, s. 40 (2).
(4)-(7) Repealed: 2004, c. 5, s. 40 (3).
(8), (9) Repealed: 2004, c. 5, s. 40 (4).

Service of notice
26. (1) Except where otherwise provided, any notice required by or provided for in this Act may be served,
(a) by personal service;
(b) by courier;
(c) by registered mail; or
(d) by any other prescribed method. 2007, c. 10, Sched. G, s. 19.

When effective
(2) Service of a notice is effective,
(a) in the case of a notice under clauses (1) (a) to (c), on the day of delivery; and
(b) in the case of a notice under clause (1) (d), as provided for in the regulations. 2007, c. 10, Sched. G, s. 19.

Service by lettermail
(3) Where an attempt has been made to effect service by a method set out in subsection (1), and for any reason service could not be effected, service may be made by lettermail. 2007, c. 10, Sched. G, s. 19.

Same
(4) Service by lettermail shall be deemed to be effective 14 business days after the day of mailing, unless the person or entity on whom service is to be made establishes that the notice was not received until a later date for reasons that he, she or it could not control, in which case service is effective on the day that the notice is actually received. 2007, c. 10, Sched. G, s. 19.

26.1 Repealed: 1996, c. 1, Sched. H, s. 19.

Proposed revision of O.M.A. schedule of fees
27. At least six months before any proposed revision of the schedule of fees of the Ontario Medical Association, the Ontario Medical Association shall notify the Minister of the proposed revision and the Minister shall arrange and implement discussions with representatives of the said Association respecting the details and extent of any proposed changes in the schedule of fees. R.S.O. 1990, c. H.6, s. 27.

Contributions to the Plan
27.1 (1) Every physician, practitioner and health facility who provides insured services shall make such contribution to the Plan as may be prescribed relating to the amount of fees payable to him, her or it under the Plan during such prior period as may be prescribed.

Amount
(2) The amount of the basic contribution from each physician, practitioner or health facility shall be determined in accordance with the regulations.

Adjustment
(3) The basic contribution from a physician, practitioner or health facility may be increased or decreased as provided in the regulations based upon such factors as may be prescribed.

Exemption
(4) Such classes of physicians, practitioners or health facilities as may be prescribed are exempt from making a contribution to the Plan. 1996, c. 1, Sched. H, s. 20.

Payments, etc., to the Plan
27.2 (1) The General Manager may obtain or recover money that a physician, practitioner or health facility owes to the Plan by set off against any money payable to him, her or it under the Plan. 1996, c. 1, Sched. H, s. 21.

Same
(2) The General Manager may obtain or recover money from a practitioner by set-off despite a review by the Medical Eligibility Committee or a practitioner review committee or an appeal to the Appeal Board from the practitioner review committee or a subsequent appeal to the Divisional Court from a decision of the Appeal Board concerning whether the money is owed to the Plan. 2007, c. 10, Sched. G, s. 20.
(3), (4) Repealed: 2004, c. 5, s. 41.

Payment by contribution to annual expenditures
28. Any amounts payable to or on behalf of an insured person under the Plan in respect of insured services provided by or in a hospital or health facility may be

paid in the form of the payment by the Province of all or any part of the annual expenditures of such hospital or health facility, where such payment by the Province is authorized under any Act. R.S.O. 1990, c. H.6, s. 28.

Disclosure authorized
29. (1) Every insured person shall be deemed to have authorized his or her physician or practitioner, a hospital or health facility which provided a service to the insured person and any other prescribed person or organization to give the General Manager particulars of services provided to the insured person,
(a) for the purpose of obtaining payment under the Plan for the services;
(b) for the purpose of enabling the General Manager to monitor and control the delivery of insured services;
(c) for the purpose of enabling the General Manager to monitor and control payments made under the Plan or otherwise for insured services; and
(d) for such other purposes as may be prescribed. 1996, c. 1, Sched. H, s. 22.

Immunity
(2) No action lies against a person or organization for giving information to the General Manager under the Act. 1996, c. 1, Sched. H, s. 22.

Exception
(3) This section does not apply where the Personal Health Information Protection Act, 2004 applies. 2004, c. 3, Sched. A, s. 85 (2).
29.1-29.8 Repealed: 2007, c. 10, Sched. G, s. 21.

Third Party Services

Third party service
36.1 (1) For the purposes of this section and sections 36.2 to 36.4, a third party service is a service that,
(a) is provided by a service provider in connection or partly in connection with,
(i) a request or requirement, made by a person or entity, that information or documentation relating to an insured person be provided, or
(ii) a request or requirement, made by a person or entity, that an insured person obtain a service from a service provider;
(b) is not an insured service or is deemed, by a regulation made under clause 45 (1) (i), not to be an insured service; and
(c) is prescribed as a third party service or is prescribed as a third party service in circumstances specified in the regulation.

Third party
(2) For the purposes of this section and sections 36.2 to 36.4, a third party is a person or entity who makes a request or requirement referred to in clause (1) (a).

Service provider
(3) For the purposes of this section and sections 36.2 to 36.4, a service provider is a physician, practitioner, hospital or health facility, or an independent health facility as defined in the Independent Health Facilities Act.

Regulations re third parties
(4) Despite subsection (2), a regulation may be made, in relation to a specified third party service or in relation to a third party service provided in specified circumstances,
(a) prescribing another person or entity as a third party instead of or in addition to the person or entity who makes the request or requirement referred to in clause (1) (a);
(b) if more than one person or entity make the request or requirement referred to in clause (1) (a), prescribing one or more of them as third parties and providing that the others are not third parties; or
(c) providing that there is no third party.

Deemed requirement or request
(5) For the purpose of subsection (1), a person or entity shall be deemed to have required or requested that information or a document relating to the insured person be provided, or that the insured person obtain a service from a service provider, if providing the information or document or obtaining the service is related to the person or entity doing or not doing anything in relation to the insured person or related to the insured person receiving or not receiving anything from the third party. 1993, c. 32, s. 2 (7).

Third party liable
36.2 (1) If a service provider who provides a third party service to an insured person renders an account for payment to the third party, the third party is liable for payment of the account, subject to subsection 36.3 (3).

Same
(2) If an insured person pays all or part of an account rendered to him or her by a service provider for a third party service provided to the insured person, the third party is liable to reimburse the insured person for the amount paid, subject to subsection 36.3 (4).

Insured person's liability to pay
(3) Nothing in this section affects any liability of an insured person to pay a service provider's account for a third party service.

Right to render account at time of service
(4) Nothing in sections 36.1 to 36.4 affects any right of a service provider to render an account for a third party service at the time the service is rendered.

No double recovery
(5) The total amount that the service provider recovers in respect of a third party service shall not exceed the amount of the account rendered. 1993, c. 32, s. 2 (7).

Amounts owing by third parties

Application of section
36.3 (1) This section applies to,
(a) an amount owing by a third party to a service provider under subsection 36.2 (1);
(b) an amount owing by a third party to an insured person under subsection 36.2 (2); and
(c) an amount owing by an insured person to a service provider for a third party service provided to the insured person by the service provider.

Proceeding to recover payment
(2) An amount referred to in subsection (1) may be recovered in a court proceeding or, if a body is designated or established under clause 45 (1.1) (f), in a proceeding before the body.

Court, body may reduce amount payable
(3) In a proceeding to recover an amount referred to in clause (1) (a) or (c), the court or body, in addition to any other order it may make, may order the third party or the insured person, as the case may be, to pay the service provider an amount that is less than the amount charged by the service provider for the third party service if the court or body finds that the amount charged by the service provider for the third party service is excessive.

Same
(4) In a proceeding to recover an amount referred to in clause (1) (b), the court or body, in addition to any other order it may make, may order the third party to pay the insured person an amount that is less than the amount paid by the insured person to the service provider for the third party service if the court or body finds that the amount charged by the service provider for the third party service is excessive.

Determining whether excessive
(5) In determining whether an amount charged by a service provider other than a physician for a third party service is excessive, the court or body shall consider any applicable guidelines respecting third party services and any applicable schedule of fees, and may consider any other relevant factors.

Same
(6) In determining whether an amount charged by a physician for a third party service is excessive, the court or body shall consider the Ontario Medical

Association's guidelines respecting third party services and its schedule of fees, and may consider any other relevant factors.

Same
(7) The Lieutenant Governor in Council may, in a regulation, provide that the court or body shall consider other matters in addition to or instead of the guidelines and schedules of fees referred to in subsections (5) and (6).

Adding service provider as party
(8) No order shall be made under subsection (4) unless the service provider has been added as a party to the proceeding.

Same
(9) The service provider may be added as a party to the proceeding referred to in subsection (4) on such terms as the court or body considers just. 1993, c. 32, s. 2 (7).
Service provider to reimburse insured person
36.4 If, under subsection 36.3 (4), the court or body orders the third party to pay the insured person an amount that is less than the amount paid by the insured person to the service provider for the third party service, the service provider is liable to repay the difference to the insured person. 1993, c. 32, s. 2 (7).

General

General information requirement
37. (1) Every physician and practitioner shall give the General Manager such information, including personal information, as may be prescribed,

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by striking out "physician and practitioner" in the portion before clause (a) and substituting "physician, practitioner, health facility, hospital and independent health facility". See: 2009, c. 26, ss. 11 (5), 27 (2).

(a) for purposes related to the administration of this Act, the Commitment to the Future of Medicare Act, 2004 or the Independent Health Facilities Act; or
(b) for such other purposes as may be prescribed. 2007, c. 10, Sched. G, s. 22 (1).

Same
(2) Such persons or organizations as may be prescribed shall give the General Manager such information, including personal information, as may be prescribed and such information as he or she may require for the purpose of administering the Act. 1996, c. 1, Sched. H, s. 30.

Time
(3) The information shall be provided in such form and within such time as the General Manager may require. 1996, c. 1, Sched. H, s. 30.

Application
(4) This section applies despite anything in the Regulated Health Professions Act, 1991, an Act listed in Schedule 1 to the Regulated Health Professions Act, 1991, the Drugless Practitioners Act or any regulations made under those Acts. 1996, c. 1, Sched. H, s. 30.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (4) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule P, section 16 by striking out "the Drugless Practitioners Act". See: 2007, c. 10, Sched. P, ss. 16, 21 (2).

Rules re providing records and information
(5) Where the General Manager requires a physician to provide records or any other information under subsection (1), the following rules apply:
1. The physician shall submit copies of the requested records or other information and, where required by the General Manager, shall include a signed certificate of authenticity and a signed copy of an audit trail for electronic records.
2. If the General Manager is not satisfied with the copies of the requested records or other information, the General Manager may require the physician to produce the original documents to the General Manager, and the documents shall be returned to the physician in a timely manner after copies have been made.
3. Where a physician fails to produce the copies or originals of records or other information required under this section, the General Manager may, on notice to the physician, apply to a provincial judge or justice of the peace for an order compelling production of the required records or other information and the provincial judge or justice of the peace may issue the order where he or she is satisfied that there are reasonable grounds for believing that the physician failed to produce the records or other information. 2007, c. 10, Sched. G, s. 22 (2).

Electronic records
(6) Where records required to be kept by physicians for the purposes of this Act are in electronic form, they shall have the characteristics of electronic records set out in the regulations under the Medicine Act, 1991. 2007, c. 10, Sched. G, s. 22 (2).

Certificate of authenticity
(7) A certificate of authenticity required under this section shall be in the form supplied by the General Manager unless otherwise prescribed. 2007, c. 10, Sched. G, s. 22 (2).

Record-keeping
37.1 (1) For the purposes of this Act, every physician, practitioner and health facility shall maintain such records as may be necessary to establish whether he, she or it has provided an insured service to a person. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (1) by striking out “physician”. See: 2007, c. 10, Sched. G, ss. 23 (1), 36 (2).

Same
(2) For the purposes of this Act, every physician, practitioner and health facility shall maintain such records as may be necessary to demonstrate that a service for which he, she or it prepares or submits an account is the service that he, she or it provided. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (2) by striking out “physician”. See: 2007, c. 10, Sched. G, ss. 23 (2), 36 (2).

Same
(3) For the purposes of this Act, every physician and health facility shall maintain such records as may be necessary to establish whether a service he, she or it has provided is medically necessary. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (3) is repealed by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (3) and the following substituted:

Same
(3) For the purposes of this Act, every health facility shall maintain such records as may be necessary to establish whether a service it has provided is medically necessary. 2007, c. 10, Sched. G, s. 23 (3).
See: 2007, c. 10, Sched. G, ss. 23 (3), 36 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 37.1 is amended by adding the following subsection:

Practitioners and health facilities
(3.1) For the purposes of this Act, every practitioner and health facility shall maintain such records as may be necessary to establish whether a service the practitioner or health facility requests is medically necessary or is rendered in the prescribed circumstances mentioned in section 18.2.1. 2009, c. 26, s. 11 (6).
See: 2009, c. 26, ss. 11 (6), 27 (2).

Same
(4) For the purposes of this Act, every practitioner and health facility shall maintain such records as may be necessary to establish whether a service he, she or it has provided is therapeutically necessary. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 37.1 is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (4) by adding the following subsection:

Same
(4.1) For the purposes of this Act, every physician shall maintain records that,
(a) comply with any requirements respecting records set out in the regulations made under the Medicine Act, 1991; and
(b) comply with any additional requirements that may be provided for in the schedule of benefits. 2007, c. 10, Sched. G, s. 23 (4).
See: 2007, c. 10, Sched. G, ss. 23 (4), 36 (2).

Same
(5) The records described in subsections (1), (2), (3) and (4) must be prepared promptly when the service is provided. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (5) is repealed and the following substituted:

Prompt preparation
(5) The records described in subsections (1), (2), (3), (3.1) and (4) must be prepared promptly after the service is requested or provided as the case may be. 2009, c. 26, s. 11 (7).
See: 2009, c. 26, ss. 11 (7), 27 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (5) is repealed by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (5) and the following substituted:

Prompt preparation
(5) The records described in subsections (1), (2), (3), (4) and (4.1) must be prepared promptly after the service is provided. 2007, c. 10, Sched. G, s. 23 (5).
See: 2007, c. 10, Sched. G, ss. 23 (5), 36 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (5) is repealed and the following substituted:

Prompt preparation
(5) The records described in subsections (1), (2), (3), (3.1), (4) and (4.1) must be prepared promptly after the service is requested or provided as the case may be. 2009, c. 26, s. 11 (8).
See: 2009, c. 26, ss. 11 (8), 27 (2).

Obligation
(6) If there is a question about whether an insured service was provided, the physician, practitioner or health facility shall provide the following persons with all relevant information within his, her or its control:

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (6) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (6) by striking out “physician” in the portion before paragraph 1. See: 2007, c. 10, Sched. G, ss. 23 (6), 36 (2).

1. The General Manager.
2. An inspector who requests the information.
3. In the case of a physician or health facility, a member of the Medical Review Committee who requests the information.

Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 3 is repealed by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (7). See: 2007, c. 10, Sched. G, ss. 23 (7), 36 (2).

4. In the case of a practitioner or health facility, a member of the applicable practitioner review committee who requests the information. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 37.1 is amended by adding the following subsection:

Same
(6.1) If there is a question about whether a service requested by a practitioner or health facility is medically necessary or is rendered in the prescribed circumstances mentioned in section

18.2.1,
(a) the practitioner or health facility shall provide the General Manager with all relevant information within his, her or its control; and
(b) in the case of a service rendered by another practitioner or health facility, or by a physician, hospital or independent health facility, the practitioner, health facility, physician, hospital or independent health facility shall provide the General Manager with all relevant information within his, her or its control. 2009, c. 26, s. 11 (9).
See: 2009, c. 26, ss. 11 (9), 27 (2).

Presumption
(7) In the absence of a record described in subsection (1), (3) or (4), it is presumed that an insured service was provided and that the basic fee payable is nil. 1996, c. 1, Sched. H, s. 31; 2002, c. 18, Sched. I, s. 8 (18).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 37.1 is amended by adding the following subsection:

Same
(7.1) In the absence of a record described in subsection (3.1), it is presumed that the service requested was not medically necessary or was rendered in the prescribed circumstances mentioned in section 18.2.1. 2009, c. 26, s. 11 (10). See: 2009, c. 26, ss. 11 (10), 27 (2).

Different service provided
(8) In the absence of a record described in subsection (2), the insured service that was provided is presumed to be the insured service, if any, that the General Manager considers to be described in the records as having been provided and not the insured service for which the account was prepared or submitted. 2002, c. 18, Sched. I, s. 8 (19).

Information confidential
38. (1) The persons listed in subsection (1.1) shall preserve secrecy with respect to all matters that come to their knowledge in the course of their employment or duties pertaining to insured persons and any insured services rendered and the payments made for those services, and shall not communicate any such matters to any other person except as otherwise provided in this Act, the Personal Health Information Protection Act, 2004 and the Freedom of Information and Protection of Privacy Act. 2007, c. 10, Sched. G, s. 24 (1).

Persons referred to in subs. (1)
(1.1) The following are listed for the purposes of subsection (1):
1. The members of the Review Board, the Appeal Board, a practitioner review committee and the Medical Eligibility Committee.
2. The employees, agents and inspectors, if any, of the Review Board, the Appeal Board, a practitioner review committee and the Medical Eligibility Committee.
3. The General Manager and persons engaged in the administration of this Act. 2007, c. 10, Sched. G, s. 24 (1).
(2), (3) Repealed: 2007, c. 10, Sched. G, s. 24 (2).

Exception for professional discipline
(4) If, in the course of the administration of this Act and the regulations, the General Manager or a practitioner review committee obtains reasonable grounds to believe that a physician or practitioner is incompetent, incapable or has

committed professional misconduct, the General Manager or the practitioner review committee, as the case may be, shall give the following information to the statutory body governing the profession of the physician or practitioner:
1. Information pertaining to the date or dates on which insured services were provided and for whom, the name and address of the hospital and health facility or person who provided the services, the amounts paid or payable by the Plan for such services and the hospital, health facility or person to whom the money was paid or is payable.
2. Information pertaining to the nature of the insured services provided by the physician or practitioner.
3. Information concerning any diagnosis given by the physician or practitioner.
4. Such other personal information as may be prescribed. 2002, c. 18, Sched. I, s. 8 (20); 2007, c. 10, Sched. G, s. 24 (3, 4).

Filing with court
38.1 A copy of any of the following may be filed with the Superior Court of Justice after the time in which an appeal may be made has passed, and once filed shall be entered in the same way as a judgment or order of the Superior Court of Justice and is enforceable as an order of that court:
1. A decision of the Appeal Board made under this Act.
2. An order of the Review Board made under this Act.
3. An agreement to reimburse the Plan signed by a physician.
4. A direction to pay the Plan given by the General Manager under clause 18 (13) (b). 2007, c. 10, Sched. G, s. 25.

Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 4 is repealed and the following substituted:
4. A direction to pay the Plan given by the General Manager under clause 18 (13) (b) or 18.2.1 (b).
See: 2009, c. 26, ss. 11 (11), 27 (2).

Protection from liability
39. (1) No action or other proceeding shall be instituted against any of the persons listed in subsection (2) for any act done in good faith in the performance or intended performance of the person's duty or for any alleged neglect or default in the performance in good faith of the person's duty. 2007, c. 10, Sched. G, s. 26 (1).

Persons referred to in subs. (1)
(2) The following are listed for the purposes of subsection (1):
1. The members of the Review Board, a practitioner review committee, the joint committee and the Medical Eligibility Committee.
2. The employees, agents or inspectors, if any, of the Review Board, a practitioner review committee, the joint committee and the Medical Eligibility Committee.
2.1 Members, employees and agents, if any, of the payment committee.

3. The General Manager and persons engaged in the administration of this Act. 2007, c. 10, Sched. G, s. 26.

General review re insured services
39.1 (1) Repealed: 2007, c. 10, Sched. G, s. 27 (1).

Same
(2) The General Manager may request a practitioner review committee to review the provision of insured services by a practitioner. The request may specify the types of insured services to be reviewed and the period during which the services were provided. 1996, c. 1, Sched. H, s. 33.

Expedited review
(3) The General Manager may request that the review be performed by a single member of the applicable committee. 1996, c. 1, Sched. H, s. 33.

Same
(4) Subsections 18.1 (6) to (9) apply with respect to a review by a single committee member. 1996, c. 1, Sched. H, s. 33.

Directions
(5) Following a review or following a reconsideration of a review by a single committee member, the practitioner review committee may direct the General Manager,
(a) to increase the amount paid to the practitioner for an insured service; or
(b) to require the practitioner to repay all or part of any payment made under the Plan. 2007, c. 10, Sched. G, s. 27 (2).

Same
(6) A direction under clause (5) (b) may be made only in the following circumstances:
1. If the applicable committee has reasonable grounds to believe that all or part of the insured services were not rendered.
2. If the applicable committee has reasonable grounds to believe that all or part of the services,
i. Repealed: 2007, c. 10, Sched. G, s. 27 (3).
ii. were not therapeutically necessary, if they were provided by a practitioner.
3. If the applicable committee has reasonable grounds to believe that the nature of the services is misrepresented, whether deliberately or inadvertently.
4. If the applicable committee has reasonable grounds to believe that all or part of the services were not provided in accordance with accepted professional standards and practice.
5. In such other circumstances as may be prescribed. 1996, c. 1, Sched. H, s. 33; 2007, c. 10, Sched. G, s. 27 (3).

Same
(7) Subsections 18.1 (14) to (16) and (18) to (20) apply following a review. 1996, c. 1, Sched. H, s. 33; 2002, c. 18, Sched. I, s. 8 (21).

Notice
(8) The applicable committee shall serve the persons affected by a direction given under subsection (5) with a notice stating that the practitioner may appeal it to the Appeal Board. 1996, c. 1, Sched. H, s. 33; 2007, c. 10, Sched. G, s. 27 (4).

Reasons for decision
(9) Upon request, the applicable committee shall give the persons affected by its direction written reasons for it. 1996, c. 1, Sched. H, s. 33.

Appeal
(10) Section 20 applies, with necessary modifications, with respect to an appeal to the Appeal Board. 1996, c. 1, Sched. H, s. 33.

Inspectors, Medical Review Committee
40. (1), (2) Repealed: 2007, c. 10, Sched. G, s. 28.

Inspectors, practitioner review committees
(3) The Minister may appoint inspectors from among the persons nominated by a body referred to in section 6 that nominates persons for appointment to a practitioner review committee. These inspectors shall act only under the direction of the applicable practitioner review committee. 1996, c. 1, Sched. H, s. 34.

Powers
(4) The powers and duties of inspectors appointed under subsection (3) relate only to the provision of insured services by practitioners engaged in the practice of the applicable health discipline. 1996, c. 1, Sched. H, s. 34.

Powers of inspectors
40.1 (1) An inspector has the following powers:
1. To interview a practitioner and members of his or her staff on matters that relate to the provision of insured services.
2. To interview persons employed in a hospital, health facility or such other type of health care facility as may be prescribed in which insured services are provided, or the operator of one, on matters that relate to the provision of insured services.
3. To question a person on matters that may be relevant to an inspection, review or reconsideration of a review, subject to the person's right to have counsel or some other representative present during the examination.
4. To enter and inspect premises where insured services are provided and to inspect the operations carried out on the premises.
5. To inspect and receive information from health records or from notes, charts and other material relating to patient care, regardless of the form or medium in

which such records or material are kept, and to reproduce and retain copies of them.
6. To inspect, at any reasonable time, all books of account, documents, correspondence and records, including payroll and employment records, regardless of the form or medium in which the records are kept, and to reproduce and retain copies of them.
7. To remove material described in paragraph 5 or 6 for the purpose of copying it. The inspector must show the certificate of his or her appointment by the Minister and must give a receipt for the material. The material must be promptly returned to the person apparently in charge of the premises from which the material is removed.
8. To enter premises where material required for the purposes of the Act, and material referred to in paragraphs 5 and 6, is stored for the purpose of inspecting it. 1996, c. 1, Sched. H, s. 34; 2007, c. 10, Sched. G, s. 29 (1).

Same
(2) An inspector has the powers of a commission under Part II of the Public Inquiries Act and may exercise them only in relation to those persons described in paragraphs 1 and 2 of subsection (1). 1996, c. 1, Sched. H, s. 34.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is repealed and the following substituted:

Same
(2) Section 33 of the Public Inquiries Act, 2009 applies to the activities of an inspector only in relation to those persons described in paragraphs 1 and 2 of subsection (1). 2009, c. 33, Sched. 6, s. 61.
See: 2009, c. 33, Sched. 6, ss. 61, 92.

Notice
(3) The inspector shall give five days written notice to the practitioner or administrator of the hospital, health facility or other health care facility that the inspector wishes to conduct an interview described in paragraph 1 or 2 of subsection (1). 1996, c. 1, Sched. H, s. 34; 2007, c. 10, Sched. G, s. 29 (2).

Same
(4) The notice must, where practicable, state the subject-matter of the interview and the identity or the position, if known, of the person or persons to be interviewed. 1996, c. 1, Sched. H, s. 34.

Same
(5) The notice must state that the person to be interviewed is entitled to be represented by legal counsel. 1996, c. 1, Sched. H, s. 34.

Private residence
(6) An inspector shall not enter a private residence without the consent of an occupier except under the authority of a warrant under subsection (7). 1996, c. 1, Sched. H, s. 34.

Warrant
(7) A provincial judge or justice of the peace may issue a warrant in the prescribed form authorizing an inspector to enter a private residence for the purpose of conducting an inspection if the judge or justice of the peace is satisfied upon application by an inspector, on information upon oath, that there are reasonable grounds for doing so. 1996, c. 1, Sched. H, s. 34.

Legible records
(8) If a book, document, item of correspondence or record is kept in a form or medium that is not legible, the inspector may require the person apparently in charge of it to provide him or her with a legible physical copy for examination. 1996, c. 1, Sched. H, s. 34.

Cost
(9) The cost of providing the inspector with a legible copy under subsection (8) shall be borne by the practitioner or health facility, as the case may be. 1996, c. 1, Sched. H, s. 34; 2007, c. 10, Sched. G, s. 29 (3).

Obstruction
40.2 (1) No person shall obstruct an inspector or withhold or conceal from an inspector any book, document, correspondence, record or thing relevant to an inspection. 1996, c. 1, Sched. H, s. 34.
(2) Repealed: 2007, c. 10, Sched. G, s. 30 (1).

Same
(3) Every practitioner who provides insured services shall co-operate fully with an inspector who is carrying out an inspection under the Act or with a member of a practitioner review committee who is exercising powers or performing duties under the Act. 1996, c. 1, Sched. H, s. 34.

Same
(4) The operator and administrator of every hospital, health facility and other health care facility in which insured services are provided shall co-operate fully with an inspector who is carrying out an inspection under the Act and shall ensure that employees also co-operate fully. 1996, c. 1, Sched. H, s. 34.

Same
(5) Every person who receives insured services shall co-operate fully with an inspector who is carrying out an inspection under the Act. 1996, c. 1, Sched. H, s. 34.
Suspension of payments

(6) The General Manager may suspend payments under the Plan to a practitioner during any period when he or she fails to comply with subsection (3) without just cause, whether or not the practitioner is convicted of an offence. 2007, c. 10, Sched. G, s. 30 (2).

Same
(7) The General Manager may suspend payments under the Plan to a hospital or health facility during any period when its operator or administrator or its employees fail to comply with subsection (4) without just cause, whether or not the person is convicted of an offence. 1996, c. 1, Sched. H, s. 34.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, section 31 by adding the following section:

Suspension of payments
40.3 (1) The General Manager may give a notice to the Review Board requesting it to hold a hearing and issue an order suspending payments or a portion of payments to a physician from the Plan, during any period when he or she fails to comply with section 37 without just cause. 2007, c. 10, Sched. G, s. 31.

Expedited review
(2) The Review Board shall commence a hearing within 30 days of receiving notice under subsection (1). 2007, c. 10, Sched. G, s. 31.

Where does not submit directly to the Plan
(3) In the case of a physician who, by virtue of section 11 of the Commitment to the Future of Medicare Act, 2004, does not submit accounts directly to the Plan, or is a physician to whom section 18.0.7 applies, the Review Board may make a further order requiring him or her to temporarily submit accounts directly to the Plan for the purpose of suspending payments under the order made under subsection (1). 2007, c. 10, Sched. G, s. 31.

Not deemed election
(4) Where a physician is required to temporarily submit his or her accounts directly to the Plan under an order of the Review Board, the submission of the accounts is not a deemed election for the purposes of subsection 11 (6) of the Commitment to the Future of Medicare Act, 2004, but subsection 10 (3) of that Act applies to him or her during the time that he or she is temporarily required to submit accounts directly to the Plan. 2007, c. 10, Sched. G, s. 31.
See: 2007, c. 10, Sched. G, ss. 31, 36 (2).

41., 42. Repealed: 2000, c. 26, Sched. H, s. 1 (7).

Offence, benefits by fraud

43. (1) No person shall knowingly obtain or attempt to obtain payment for or receive or attempt to receive the benefit of any insured service that the person is not entitled to obtain or receive under this Act and the regulations.

Idem
(2) No person shall knowingly aid or abet another person to obtain or attempt to obtain payment for or receive or attempt to receive the benefit of any insured service that such other person is not entitled to obtain or receive under this Act and the regulations.

False information
(3) No person shall knowingly give false information in an application, return or statement made to the Plan or to the General Manager in respect of any matter under this Act or the regulations. R.S.O. 1990, c. H.6, s. 43.

Mandatory reporting
43.1 (1) A prescribed person who, in the course of his or her professional or official duties, has knowledge that an event referred to in subsection (2) has occurred shall promptly report the matter to the General Manager.

Events
(2) Subsection (1) applies to the following events:
1. An ineligible person receives or attempts to receive an insured service as if he or she were an insured person.
2. An ineligible person obtains or attempts to obtain reimbursement by the Plan for money paid for an insured service as if he or she were an insured person.
3. An ineligible person, in an application, return or statement made to the Plan or the General Manager, gives false information about his or her residency.

Definition, "ineligible person"
(3) In subsection (2),
"ineligible person" means a person who is neither an insured person nor entitled to become one.

Defence
(4) It is a defence to a proceeding for failure to make a report required by subsection (1) that the prescribed person delayed making the report because he or she believed, on reasonable grounds, that making the report might be a direct and immediate cause of serious bodily harm to a person, and made the report as soon as he or she was of the opinion that the danger no longer existed.

Voluntary reporting
(5) A prescribed person may report to the General Manager any matter relating to the administration or enforcement of this Act or the regulations.

Subss. (1) and (5) prevail

(6) Subsections (1) and (5) apply even if the information reported is confidential or privileged and despite any Act, regulation or other law prohibiting disclosure of the information.

Protection from liability
(7) No proceeding for making a report under subsection (1) or (5) or for providing information in connection with the report shall be commenced against a person unless he or she acts maliciously and the information on which the report is based is not true.

Exception: solicitor-client privilege
(8) Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client. 1993, c. 32, s. 2 (8).

General penalty, individual
44. (1) Every individual who contravenes any provision of this Act or the regulations for which no penalty is specifically provided is guilty of an offence and is liable,
(a) for a first offence, to a fine of not more than $25,000 or to imprisonment for a term of not more than 12 months, or to both;
(b) for a subsequent offence, to a fine of not more than $50,000 or to imprisonment for a term of not more than 12 months, or to both. 2002, c. 18, Sched. I, s. 8 (22).

No imprisonment for record-keeping offences
(1.1) Despite subsection (1), no person may be sentenced to a term of imprisonment for failing to keep or maintain records under section 37.1. 2007, c. 10, Sched. G, s. 32.

Same, corporation
(2) Every corporation that contravenes any provision of this Act or the regulations for which no penalty is specifically provided is guilty of an offence and is liable to a fine of not more than $50,000 for a first offence and to a fine of not more than $200,000 for a subsequent offence. 2002, c. 18, Sched. I, s. 8 (22).

Compensation or restitution
(3) The court that convicts a person of an offence under this section may, in addition to any other penalty, order that the person pay compensation or make restitution to any person who suffered a loss as a result of the offence. 2002, c. 18, Sched. I, s. 8 (22).

No limitation
(4) Section 76 of the Provincial Offences Act does not apply to a prosecution under this section. 2002, c. 18, Sched. I, s. 8 (22).

Health Insurance Act
R.R.O. 1990, REGULATION 552

Amended to O. Reg. 352/04

GENERAL

DEFINITIONS

1. (1) In this Regulation,
"benefit period" means the period of time during which an insured person is entitled to insured services;

"dental surgeon" means a person entitled to practise dentistry in the place where dental services are rendered by the surgeon;

"extended class nursing staff" means those registered nurses in the extended class in a hospital,

(a) who are employed by the hospital and are authorized to diagnose, prescribe for or treat out-patients in the hospital, and

(b) who are not employed by the hospital and to whom the governing body or authority of the hospital has granted privileges to diagnose, prescribe for or treat out-patients in the hospital;

"hospital" means any hospital that is designated under this Regulation to participate in the Plan;

"in-patient" means a person admitted to and assigned a bed in a hospital in-patient area;

"midwife" means a member of the College of Midwives of Ontario;

"nursing home" means a nursing home operated or maintained under the authority of a licence
issued under the *Nursing Homes Act*;

"oral and maxillofacial surgeon" means,

(a) with respect to dental services rendered in Ontario, a dental surgeon who holds a specialty certificate of registration from the Royal College of Dental Surgeons of Ontario authorizing the surgeon to practise oral and maxillofacial surgery in Ontario,

(b) with respect to dental services rendered elsewhere in Canada, a person who holds a designation from a professional regulatory body in the Canadian province or territory outside of Ontario where the services are rendered that, in the opinion of the General
Manager, is equivalent to the designation referred to in clause (a), or

(c) with respect to dental services rendered outside Canada, a person who is authorized to practise oral and maxillofacial surgery in the jurisdiction outside Canada where the services are rendered and holds, in the opinion of the General Manager, a designation equivalent to the designation referred to in clause (a);

"out-patient" means a person who receives out-patient services and is not admitted to an inpatient area;

"prescribed form" means the form prescribed by the General Manager for the purpose;

"registered nurse in the extended class" means a member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the *Nursing Act, 1991*;

"same-sex partner" means a person of the same sex with whom the person is living, in a conjugal relationship outside marriage, if the two persons,

(a) have cohabited for at least one year,

(b) are together the parents of a child, or

(c) have together entered into a cohabitation agreement under section 53 of the *Family Law Act*;

"schedule of benefits" means the document published by the Ministry of Health and Long-Term Care titled "Schedule of Benefits — Physician Services under the *Health Insurance Act* (July 1, 2003)" and includes the following amendments, but does not include the "[Commentary…]" portions of the document:

1. Amendments dated August 1, 2003.
2. Amendments dated September 1, 2003.
3. Amendments dated November 1, 2004.
4. Amendments dated December 1, 2004;

"schedule of laboratory benefits" means the document published by the Ministry of Health andLong-Term Care titled "Schedule of Benefits for Laboratory Services", dated April 1, 1999, together with the following documents, all of which can be accessed on the Ministry's website www.health.gov.on.ca by clicking on the Health Care Providers link, the OHIP for Healthcare Professionals link and on the Ontario Health Insurance Schedule of Benefits and Fees link:

1. The Ministry of Health and Long-Term Care document titled "Addendum Dated April 1, 2001 to Schedule of Benefits for Laboratory Services".
2. The Ministry of Health and Long-Term Care document titled "Addendum Dated April 1, 2004 to Schedule of Benefits for Laboratory Services".
3. The Ministry of Health and Long-Term Care document titled "Addendum Dated August 16, 2004 to Schedule of Benefits for Laboratory Services";

"schedule of optometry benefits" means the document published by the Ministry of Health and Long-Term Care titled "Schedule of Benefits for Optometry Services" (November 1, 2004), but does not include the "[Commentary…]" portions of the document, or any appendix to the document;

"spouse" means a person of the opposite sex,

(a) to whom the person is married, or

(b) with whom the person was living, in a conjugal relationship outside marriage, if the two persons,

(i) have cohabited for at least one year,

(ii) are together the parents of a child, or

(iii) have together entered into a cohabitation agreement under section 53 of the *Family Law Act*;

"standard ward accommodation" means,

(a) a bed in a hospital area designated by the hospital in accordance with Regulation 794 of the Revised Regulations of Ontario, 1990 under the *Ministry of Health Act* as a standard ward, or

(b) Revoked: O. Reg. 375/93, s. 1.

R.R.O. 1990, Reg. 552, s. 1; O. Reg. 616/91, s. 1 (1); O. Reg. 214/93, s. 1; O. Reg. 375/93, s. 1; O. Reg. 794/93, s. 1; O. Reg. 488/94, s. 1; O. Reg. 114/96, s. 1; O. Reg. 409/96, s. 1 (1); O. Reg. 410/96, s. 1; O. Reg. 502/97, s. 1 (1); O. Reg. 44/98, s. 1; O. Reg. 147/98, s. 1; O. Reg. 375/98, s. 1 (1); O. Reg. 376/98, s. 1; O. Reg. 378/98, s. 1; O. Reg. 478/98, s. 1; O. Reg. 178/99, s. 1 (1-5); O. Reg. 201/99, s. 1; O. Reg. 482/99, s. 1; O. Reg. 67/00, s. 1; O. Reg. 322/00, s. 1; O. Reg. 368/00, s. 1 (1); O. Reg. 617/00, s. 1; O. Reg. 66/01, s. 1; O. Reg. 250/01, s. 1 (1); O. Reg. 272/01, s. 1 (1); O. Reg. 345/01, s. 1; O. Reg. 415/01, s. 1; O. Reg. 56/02, s. 1 (1); O. Reg. 169/02, s. 1 (1); O. Reg. 302/02, s. 1 (1); O. Reg. 361/02, s. 1 (1); O. Reg. 18/03, s. 1; O. Reg. 50/03, s. 1; O. Reg. 62/03, s. 1; O. Reg. 203/03, s. 1; O. Reg. 221/03, s. 1; O. Reg. 265/03, s. 1 (1); O. Reg. 266/03, s. 1; O. Reg. 350/03, s. 1; O. Reg. 6/04, s. 1; O. Reg. 238/04, s. 1; O. Reg. 320/04, s. 1 (1, 2); O. Reg. 352/04, s. 1.

(2) A reference to the schedule of benefits or the schedule of optometry benefits in relation to a service is a reference to the relevant schedule in force at the time the service was rendered. O. Reg. 320/04, s. 1 (3).

(3) Appendices A, B, C and F of the document titled "Schedule of Benefits — Physician Services under the *Health Insurance Act* (July 1, 2000)" do not form part of the schedule of benefits for the purposes of this Regulation. O. Reg. 368/00, s. 1 (2).

(4) Revoked: O. Reg. 265/03, s. 1 (2).

17. (1) A service rendered by an optometrist in Ontario is an insured service if it is referred to in the schedule of optometry benefits and is rendered in the circumstances or under the conditions referred to in the schedule of optometry benefits. O. Reg. 320/04, s. 2.

(2) The basic fee payable by the Plan for an insured service prescribed under subsection

(1) is the fee payable under the schedule of optometry benefits. O. Reg. 320/04, s. 2.

EXCLUSIONS

24. (1) The following services rendered by physicians or practitioners are not insured services and are not part of insured services unless, in the case of services rendered by physicians, they are specifically listed as an insured service or as part of an insured service in the schedule of benefits or, in the case of services rendered by optometrists, they are specifically listed as an insured service or as part of an insured service in the schedule of optometry benefits:

1. Travelling to visit an insured person outside the usual geographical area of practice of the person making the visit.

2. Toll charges for long distance telephone calls.

3. Preparing or providing a device that is not implanted by means of an incision and that is used for therapeutic purposes unless,

i. the device is used to permit or facilitate a procedure or examination, or

ii. the device is a cast for which there is a fee listed in the schedule of benefits.

4. Preparing or providing,

i. a drug, antigen, antiserum or other substance used for treatment that is not used to facilitate a procedure or examination, or

ii. a drug to promote ovulation.

5. Advice given by telephone to an insured person at the request of the person or the person's representative.

6. An interview or case conference in respect of an insured person that,

i. lasts more than twenty minutes, and

ii. includes a professional, none of whose services are insured services.

7. The preparation and transfer of an insured person's health records when this is done because the care of the person is being transferred at the request of the person or the person's representative.

8. A service, including an annual health or annual physical examination, received wholly or partly for the production or completion of a document or the transmission of information to which paragraph 8.1 or 8.2 applies regardless of whether the document or information was requested before, at the same time as or after the service was received.

8.1 The production or completion of a document, or the transmission of information to any person other than the insured person, if the document or transmission of information is required by legislation of any government

or is to be used to receive anything under, or to satisfy a condition under, any legislation or program of a government.

8.2 The production or completion of a document, or the transmission of information to any person other than the insured person, if the document or the transmission of the information relates to,

i. admission to or continued attendance in a day care or pre-school program
or a school, community college, university or other educational institution or program,
ii. admission to or continued attendance in a recreational or athletic club, association or program or a camp,
iii. an application for, or the continuation of, insurance,
iv. an application for, or the continuation of, a licence,
v. entering or maintaining a contract,
vi. an entitlement to benefits, including insurance benefits or benefits under a pension plan,
vii. obtaining or continuing employment,
viii. an absence from or return to work,
ix. legal proceedings.

9. The providing of a prescription to an insured person if the person or the person's personal representative requests the prescription and no concomitant insured service is provided.

10. A service that is solely for the purpose of altering or restoring appearance.

11. An anaesthetic service rendered by a physician in connection with,

i. a service rendered by a practitioner that is provided outside a hospital, or
ii. a dental service that is not insured, is provided in a hospital and involves only the removal of impacted teeth.

12. The fitting of contact lenses other than for,

i. aphakia,
ii. myopia greater than 9 dioptres,
iii. irregular astigmatism resulting from post corneal grafting or corneal scarring from disease, or
iv. keratoconus.

13. An acupuncture procedure.

14. Psychological testing.

15. Revoked: O. Reg. 295/04, s. 1 (1).

16. An examination or procedure for the purpose of a research or survey program other than an assessment that is necessary to determine if an insured person is suitable for the program.

17. Treatment for a medical condition that is generally accepted within Ontario as experimental.

18. Psychotherapy that is a requirement for the patient to obtain a diploma or degree or to fulfil a course of study.

19. A missed appointment or procedure.

20. Destruction of hair follicles.

21. Circumcision, except if medically necessary.

22. Reversal of sterilization.

23. *In vitro* fertilization other than the first three treatment cycles of *in vitro* fertilization that are intended to address infertility due to complete bilateral anatomical fallopian tube blockage that did not result from sterilization.

24. Counselling, therapy or any other service rendered for the purpose of weight loss for the benefit of a patient other than a patient,

i. who has a medical condition that is attributable to, or aggravated by, excess weight, or

ii. who suffers from obesity and whose obesity puts the patient at an increased risk of developing a medical condition that is attributable to, or aggravated by, excess weight.

25. A service or treatment, including immunization or the administration of any drug, rendered to an insured person in connection with, and for the sole purpose of, travelling to a country outside Canada.

26. Sex-reassignment surgery.

27. The fitting or evaluation of hearing aids and tinnitus maskers.

28. A service rendered to a person who is 20 or more years of age and less than 65 years of age that is rendered solely for the purpose of refraction. R.R.O. 1990, Reg. 552, s. 24 (1); O. Reg. 617/91, s. 1; O. Reg. 785/92, s. 1 (1); O. Reg. 488/94, s. 2 (1, 2); O. Reg. 790/94, s. 1; O. Reg. 176/95, s. 1 (1); O. Reg. 146/98, s. 1 (1, 2); O. Reg. 377/98, s. 1 (1); O. Reg. 528/98, s. 2 (1); O. Reg. 617/00, s. 2; O. Reg. 250/01, s. 2 (1); O. Reg. 272/01, s. 2 (1, 2); O. Reg. 295/04, s. 1 (1); O. Reg. 320/04, s. 3 (1, 2).

(1.0.1) Subparagraph 4 i of subsection (1) does not apply with respect to the preparation or provision of verteporfin on or after June 15, 2002 if all of the following conditions exist:

1. The verteporfin is provided in the course of ocular photodynamic therapy for the treatment of predominantly classic subfoveal choroidal neovascularization secondary to age-related macular degeneration or pathologic myopia.

2. The area of classic subfoveal choroidal neovascularization is equal to or greater than 50 per cent of the total lesion, as determined by fluorescein angiography.

3. The first treatment is commenced within 30 months after the initial diagnosis of predominantly classic subfoveal choroidal neovascularization secondary to age-related macular degeneration or pathologic myopia.

4. The patient's visual acuity is 20/40 or worse. O. Reg. 169/02, s. 3.

(1.1) Paragraphs 8, 8.1 and 8.2 of subsection (1) do not apply to:

1. Keeping or maintaining appropriate physician or practitioner records.

2. Conferring with or providing advice, direction, information or records to physicians or other professionals concerned with the health of the insured person.

3. Producing or completing documents or transmitting information,
   i. required to satisfy a condition of being admitted to, or receiving health services in, a hospital, nursing home, a home as defined in the *Homes for the Aged and Rest Homes Act*, a home for retarded persons as defined in the *Homes for Retarded Persons Act* or a charitable institution as defined in the *Charitable Institutions Act*,
   ii. required in relation to an annual health or annual physical examination of a patient or resident of any facility mentioned in subparagraph i,
   iii. required to receive anything under a program administered by the Minister of Health,
   iv. required to receive welfare or social assistance benefits provided by a government or vocational rehabilitation services under the *Vocational Rehabilitation Services Act*,
   v. required by or for a health facility as defined in the *Independent Health Facilities Act*,
   vi. respecting the health status of a child who,
      A. is in the supervision, or under the care, custody or control of a children's aid society,

B. resides in a place of secure custody, a place of open custody or a place of temporary detention, within the meaning of Part IV of the *Child and Family Services Act*, or
C. resides in a children's residence licensed under Part IX of the *Child and Family Services Act*,

vii. required, as evidence of immunization status, for admission to or continued attendance in a day care or pre-school program or a school, community college, university or other educational institution or program,

viii. required as evidence of disability, for the purposes of eligibility for a benefit, related to transportation, under any legislation or program of a government, or

ix. to obtain consents to the performance of insured services.

4. A service received wholly or partly for the production or completion of a document or the transmission of information to which paragraph 3 applies.

5. An examination rendered and documents produced or completed or information transmitted under the *Mental Health Act*.

6. An examination rendered and documents produced or completed or information transmitted for the purpose of an investigation or confirmation of an alleged sexual assault in accordance with the requirements of the Ministry of the Attorney General and the Ministry of the Solicitor General. O. Reg. 785/92, s. 1 (2).

(1.2) Paragraph 8 of subsection (1) does not apply to a service that is, in the opinion of the physician or practitioner, medically necessary and that is received wholly or partly for the production or completion of a document or the transmission of information that relates to any of the following:

1. The receipt of disability or sickness benefits or the satisfaction of a condition relating to disability or sickness benefits.

2. A return to a day care or pre-school program after a temporary absence.

3. A condition relating to fitness to continue employment other than a condition that requires an examination or assessment to be conducted on an annual or other periodic basis.

4. An absence from or return to work.

5. Legal proceedings. O. Reg. 785/92, s. 1 (2).

Health Insurance Act
ONTARIO REGULATION 22/02
Amended to O. Reg. 46/04

SUBMISSION OF ACCOUNTS

Definition

1. In this Regulation,
"in-patient" means a person admitted to and assigned a bed in a hospital in-patient area. O. Reg. 22/02, s. 1.

Time limits for submitting accounts

2. A physician, practitioner, health facility or, in the case of a patient who is billed directly, the patient shall submit an account for an insured service to the General Manager no later than the following:

1. For insured services rendered in Ontario, no later than six months after the service is rendered.
2. For insured services rendered outside Ontario,
    i. no later than 12 months after the date of the patient's discharge for services rendered to inpatients, and
    ii. in all other cases, no later than 12 months after the service is rendered. O. Reg. 22/02, s. 2.

Exception

3. Paragraph 2 of section 2 does not apply to services rendered outside Ontario that are approved by the General Manager for payment before the service is rendered. O. Reg. 22/02, s. 3.

Transition

4. This Regulation applies to accounts submitted on or after January 1, 2002. O. Reg. 22/02, s. 4; O. Reg. 46/04, s. 1.

5. Omitted (provides for coming into force of provisions of this Regulation). O. Reg. 22/02, s. 5.

Health Protection and Promotion Act

The *Health Protection and Promotion Act* requires that an optometrist who "forms the opinion that the person has or may have a reportable disease shall" report this fact to the Medical Officer of Health of the health unit in which the professional services are provided. The report must be filed as soon as possible after forming the opinion. The actual diseases that are to be reported are set out in the Act's regulations.

If a patient informs you that they have a reportable disease, the diagnosis has already been made by another healthcare professional and you are not required to make a mandatory report. The following diseases are specified as reportable diseases for the purposes of the *Health Protection and Promotion Act:*

AIDS
Amebiasis
Anthrax
Botulism
Brucellosis
Campylobacter enteritis
Chancroid
Chickenpox (Varicella)
Chlamydia trachomatis infections
Cholera
Clostridium difficile associated disease (CDAD) outbreaks in public hospitals
Cryptosporidiosis
Cyclosporiasis
Cytomegalovirus infection, congenital
Diphtheria
Encephalitis, including,

i. Primary, viral
ii. Post-infectious
iii. Vaccine-related
iv. Subacute sclerosing panencephalitis
v. Unspecified food poisoning, all causes

Gastroenteritis, institutional outbreaks
Giardiasis, except asymptomatic cases
Gonorrhoea
Group A Streptococcal disease, invasive
Group B Streptococcal disease, neonatal
Haemophilus influenzae b disease, invasive
Hantavirus pulmonary syndrome
Hemorrhagic fevers, including,

i. Ebola virus disease
ii. Marburg virus disease
iii. Other viral causes

Hepatitis, viral,
    i. Hepatitis A
    ii. Hepatitis B
    iii. Hepatitis C
    iv. Hepatitis D (Delta hepatitis)
Herpes, neonatal
Influenza
Lassa Fever
Legionellosis
Leprosy
Listeriosis
Lyme Disease
Malaria
Measles
Meningitis, acute,
    i. bacterial
    ii. viral
    iii. other
Meningococcal disease, invasive
Mumps
Ophthalmia neonatorum
Paratyphoid Fever
Pertussis (Whooping Cough)
Plague
Pneumococcal disease, invasive
Poliomyelitis, acute
Psittacosis/Ornithosis
Q Fever
Rabies
Respiratory infection outbreaks in institutions
Rubella
Rubella, congenital syndrome
Salmonellosis
Severe Acute Respiratory Syndrome (SARS)
Shigellosis
Smallpox
Syphilis
Tetanus
Transmissible Spongiform Encephalopathy, including,
    i. Creutzfeldt-Jakob Disease, all types
    ii. Gerstmann-Sträussler-Scheinker Syndrome
    iii. Fatal Familial Insomnia
    iv. Kuru
Trichinosis
Tuberculosis
Tularemia

Typhoid Fever
Verotoxin-producing E. coli infection indicator conditions, including Haemolytic Uraemic Syndrome (HUS)
West Nile Virus Illness
Yellow Fever
Yersiniosis

Health Protection and Promotion Act

R.S.O. 1990, CHAPTER H.7

Amended by: 1992, c. 32, s. 16; 1994, c. 26, s. 71; 1996, c. 2, s. 67; 1997, c. 15, s. 5; 1997, c. 26, Sched.; 1997, c. 30, Sched. D, ss. 1-16; 1998, c. 18, Sched. G, s. 55; 1999, c. 2, s. 36; 1999, c. 12, Sched. J, s. 32; 2000, c. 5, s. 14; 2001, c. 13, s. 17; 2001, c. 25, s. 477; 2001, c. 30; 2002, c. 17, Sched. F, Table; 2002, c. 18, Sched. I, s. 9; 2002, c. 32, s. 171; 2003, c. 1, s. 15; 2004, c. 3, Sched. A, s. 86; 2004, c. 30.

Duty to report disease

25. (1) A physician or a practitioner as defined in subsection (2) who, while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a reportable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided. R.S.O. 1990, c. H.7, s. 25; 1998, c. 18, Sched. G, s. 55 (2).

Definition

(2) In subsection (1),

"practitioner" means,

(a) a member of the College of Chiropractors of Ontario,

(b) a member of the Royal College of Dental Surgeons of Ontario,

(c) a member of the College of Nurses of Ontario,

(d) a member of the Ontario College of Pharmacists,

(e) a member of the College of Optometrists of Ontario, or

(f) a person registered as a drugless practitioner under the *Drugless Practitioners Act*. 1998, c. 18, Sched. G, s. 55 (3).

Confidentiality

39. (1) No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a reportable disease, a virulent disease or a reportable event following the administration of an immunizing agent. R.S.O. 1990, c. H.7, s. 39 (1).

Exceptions

(2) Subsection (1) does not apply,

(a) in respect of an application by a medical officer of health to the Ontario Court of Justice that is heard in public at the request of the person who is the subject of the application;

(b) where the disclosure is made with the consent of the person in respect of whom the application, order, certificate or report is made;

(c) where the disclosure is made for the purposes of public health administration;

(d) in connection with the administration of or a proceeding under this Act, the *Regulated Health Professions Act, 1991*, a health profession Act as defined in subsection 1 (1) of that Act, the *Public Hospitals Act*, the *Health Insurance Act*, the *Canada Health Act* or the *Criminal Code* (Canada), or regulations made thereunder; or

(e) to prevent the reporting of information under section 72 of the *Child and Family Services Act* in respect of a child who is or may be in need of protection. R.S.O. 1990, c. H.7, s. 39 (2); 1998, c. 18, Sched. G, s. 55 (5); 1999, c. 2, s. 36; 2002, c. 18, Sched. I, s. 9 (5).

Highway Traffic Act

Under the Highway Traffic Act, “every member of the College of Optometrists of Ontario shall report to the Registrar [of Motor Vehicles] the name, address and clinical condition of every person sixteen years of age or over attending upon the optometrist for optometric services who, in the opinion of the optometrist, is suffering from an eye condition that may make it dangerous for the person to operate a motor vehicle”. Reporting is mandatory and supersedes confidentiality requirements.

Optometrists must also report every person sixteen years of age or over with the following high-risk visual impairments:

- A best corrected visual acuity that is below 20/50 with both eyes open and examined together.
- A visual field that is less than 120 continuous degrees along the horizontal meridian, or less than 15 continuous degrees above and below fixation, or less than 60 degrees to either side of the vertical midline, including hemianopia.
- Diplopia that is within 40 degrees of fixation point (in all directions) of primary position, that cannot be corrected using prism lenses or patching.

Where the horizontal visual field of a driver is to be determined,

(a) it shall be measured without the aid of extraordinary optical devices that enhance or modify vision or that interfere with the horizontal visual field, such as telescopic lenses, prism lenses or sidebar prisms;
(b) the continuous horizontal visual field shall not include the natural blind spot;
(c) the visual field representation must include the central visual fixation point at its centre;
(d) no less than half of the continuous degrees of the horizontal visual field that are required along the horizontal meridian shall be found on either side of the vertical meridian; and
(e) the continuous degrees of the horizontal visual field that are required above and below fixation shall be continuous throughout the required continuous degrees along the horizontal meridian.

As a reminder to members, the current vision requirements for the issuance of a driver’s licence are below. These standards may be met with or without the aid of corrective lenses:

Private Passenger Vehicles (Classes G, M)
• 20/50 with both eyes open and tested together
• 120° continuous horizontal visual field, 15° continuous vertical visual field with both eyes tested together

Commercial / Bus Vehicles (Classes A - F)

- 20/30 with both eyes open, tested together --- worse eye no poorer than 20/100
- 150° continuous horizontal visual field, 20° continuous vertical visual field with both eyes tested together

It is important to note that this reporting requirement pertains not only to those persons who currently have or are trying to obtain a driver's licence, but to "any person sixteen years of age or over".

A waiver/individual assessment program is available for class G, G1, G2 applicants or holders who do not meet the horizontal visual field standard.

Furthermore, the reporting obligation may arise in a situation where the optometrist is acting as a consultant for such activities as industrial or third party examinations or assessments.

In addition to reporting those persons who do not meet the legislated requirements for the class of driver's licence they hold, optometrists are also responsible for reporting any person with "an eye condition that may make it dangerous for the person to operate a motor vehicle."

The report must be made in writing and sent to the Registrar of Motor Vehicles at the Ministry of Transportation. Report forms are available by contacting the Ministry. Although the Act does not specify a time period in which the report must be made, it should be done as soon as possible after the information is obtained.

The Ontario Court of Appeal has confirmed that the mandatory reporting requirement of the *Highway Traffic Act* must be complied with even if in the practitioner's professional judgment, a report is unnecessary.

In the past, two physicians were sued for failing to report to the Ministry of Transportation that their patient (shared management) should not be driving. The physicians argued that the patient was aware of his limitations, that they instructed the patient not to drive, and the patient could be trusted not to drive. The patient was, therefore, not a risk, and did not require a report to be filed. The physicians also argued that a practice had developed not to report in every case. They stated that the burden of the broadly worded provision was onerous and impractical, so professional judgment was exercised as to which cases ought to be reported.

The court rejected all of these arguments. The duty to report was mandatory and must be obeyed. It was a duty owed to the public and not just the patient. Failure to fulfill the duty would lead to civil liability where the failure contributes to damage to others. The two physicians in this case were liable, along with others, for more than $600,000 in damages.

Bioptics Now Allowed For Driving

The HTA now allows for the use of telescopic lenses due to a recent regulation change. Regulation 340/94 subsection 18(2) allow drivers to use telescopic lenses to pass the acuity test. The Ministry requires a vision report which confirms the individual meets the required visual acuity standards with the use of the telescopic lenses. The report may be completed by an optometrist or ophthalmologist.

Highway Traffic Act

R.S.O. 1990, CHAPTER H.8

Amended by: 1992, c. 20, s. 2; 1993, c. 8; 1993, c. 13, s. 1; 1993, c. 18; 1993, c. 27, Sched.; 1993, c. 31, s. 2; 1993, c. 34; 1993, c. 40; 1994, c. 27, s. 138; 1994, c. 28; 1994, c. 29; 1994, c. 35; 1996, c. 1, Sched. E, s. 2; 1996, c. 9, s. 26; 1996, c. 20; 1996, c. 31, ss. 68-71; 1996, c. 32, s. 71; 1996, c. 33, ss. 1-17; 1997, c. 4, s. 81; 1997, c. 12; 1997, c. 26, Sched.; 1997, c. 41, s. 120; 1998, c. 5, ss. 25-27; 1998, c. 6; 1998, c. 18, Sched. G, s. 56; 1998, c. 28, s. 67; 1998, c. 35, s. 103; 1998, c. 38; 1999, c. 8, s. 7; 1999, c. 12, Sched. B, s. 9; 1999, c. 12, Sched. G, s. 24; 1999, c. 12, Sched. R, ss. 1-19; 1999, c. 13; 2000, c. 15; 2000, c. 26, Sched. O; 2000, c. 29; 2000, c. 30, s. 10; 2000, c. 35; 2001, c. 4, s. 4; 2001, c. 9, Sched. O; 2001, c. 13, s. 18; 2001, c. 32, s. 26; 2002, c. 4, s. 64; 2002, c. 5, s. 32; 2002, c. 15; 2002, c. 17, Sched. C, s. 15; 2002, c. 17, Sched. F, Table; 2002, c. 18, Sched. P, ss. 1-39; 2002, c. 21; 2002, c. 22, ss. 95-101; 2002, c. 24, Sched. B, s. 25; 2002, c. 30, Sched. E, s. 7; 2004, c. 22, ss. 1-6; 2004, c. 31, Sched. 18; 2012, c. 8, Sched. 22, s.20; 2014, c. 9, Sched. 2; 2015, c. 14, s. 4-59, 61; 2015, c. 27, Sched 7; 2016, c. 5, Sched. 12; 2017, c. 2, Sched 17; 2017, c. 9; 2017, c. 26, Sched 1, s. 31; 2017, c. 26, Sched. 4; 2017, c. 34, Sched 19, s. 22; 2017, c. 34, Sched. 35, s. 27, 29; 2018, c. 3, Sched. 5, s. 26.

Medical reports
Mandatory reports
203 (1) Every prescribed person shall report to the Registrar every person who is at least 16 years old who, in the opinion of the prescribed person, has or appears to have a prescribed medical condition, functional impairment or visual impairment. 2015, c. 14, s. 55.

Discretionary reports
(2) A prescribed person may report to the Registrar a person who is at least 16 years old who, in the opinion of the prescribed person, has or appears to have a medical condition, functional impairment or visual impairment that may make it dangerous for the person to operate a motor vehicle. 2015, c. 14, s. 55.

Authority to make discretionary report prevails over duty of confidentiality
(3) The authority to make a report under subsection (2) prevails over any duty of confidentiality imposed on the prescribed person by or under any other Act or by a standard of practice or rule of professional conduct that would otherwise preclude him or her from providing the information described in that subsection to the Registrar. 2015, c. 14, s. 55.

Required to meet the person
(4) Subsections (1) and (2) only apply if the prescribed person actually met the reported person for an examination or for the provision of medical or other services, or in the circumstances prescribed by regulation. 2015, c. 14, s. 55.

Authority to make discretionary report is not a duty
(5) Subsections (2) and (3) do not impose a duty on a prescribed person to report to the Registrar. 2015, c. 14, s. 55.

General rules respecting medical reports
Contents
204 (1) A report required or authorized by section 203 must be submitted in the form and manner specified by the Registrar and must include,

(a) the name, address and date of birth of the reported person;

(b) the condition or impairment diagnosed or identified by the person making the report, and a brief description of the condition or impairment; and

(c) any other information requested by the form. 2015, c. 14, s. 55.

No liability for compliance
(2) No action or other proceeding shall be brought against a prescribed person required or authorized to make a report under section 203 for making such a report or for reporting to the Registrar in good faith with the intention of reporting under that section. 2015, c. 14, s. 55.

Reports privileged
(3) A report made under section 203, or made to the Registrar in good faith with the intention of reporting under that section, is privileged for the information of the Registrar only and shall not be open to public inspection. 2015, c. 14, s. 55.

Regulations
(4) The Lieutenant Governor in Council may make regulations governing reports made under section 203, including regulations,

(a) prescribing persons for the purpose of subsection 203 (1) or (2);

(b) prescribing medical conditions, functional impairments or visual impairments for the purpose of subsection 203 (1);

(c) prescribing circumstances for the purpose of subsection 203 (4). 2015, c. 14, s. 55.

Highway Traffic Act
(Excerpt)
(Effective July 1, 2018)

ONTARIO REGULATION 340/94

14.1 (1) For the purposes of subsection 203 (1) of the Act, the following are the prescribed persons who shall report under that subsection: an optometrist, a nurse practitioner and a physician. O. Reg. 38/18, s. 3.

(2) For the purposes of subsection (1), an optometrist is prescribed only with respect to visual impairments. O. Reg. 38/18, s. 3.

(3) For the purposes of subsection 203 (1) of the Act, the following are the prescribed medical conditions, functional impairments and visual impairments that a prescribed person under subsection (1) shall report:

1. Cognitive impairment: a disorder resulting in cognitive impairment that,
    i. affects attention, judgment and problem solving, planning and sequencing, memory, insight, reaction time or visuospatial perception, and
    ii. results in substantial limitation of the person's ability to perform activities of daily living.
2. Sudden incapacitation: a disorder that has a moderate or high risk of sudden incapacitation, or that has resulted in sudden incapacitation and that has a moderate or high risk of recurrence.
3. Motor or sensory impairment: a condition or disorder resulting in severe motor impairment that affects co-ordination, muscle strength and control, flexibility, motor planning, touch or positional sense.
4. Visual impairment:
    i. A best corrected visual acuity that is below 20/50 with both eyes open and examined together.
    ii. A visual field that is less than 120 continuous degrees along the horizontal meridian, or less than 15 continuous degrees above and below fixation, or less than 60 degrees to either side of the vertical midline, including hemianopia.
    iii. Diplopia that is within 40 degrees of fixation point (in all directions) of primary position, that cannot be corrected using prism lenses or patching.
5. Substance use disorder: a diagnosis of an uncontrolled substance use disorder, excluding caffeine and nicotine, and the person is non-compliant with treatment recommendations.
6. Psychiatric illness: a condition or disorder that currently involves acute psychosis or severe abnormalities of perception such as those present in schizophrenia or in other psychotic disorders, bipolar disorders, trauma or stressor-related disorders,

dissociative disorders or neurocognitive disorders, or the person has a suicidal plan involving a vehicle or an intent to use a vehicle to harm others. O. Reg. 38/18, s. 3.

(4) A person prescribed under subsection (1) is not required under subsection 203 (1) of the Act to report a person whose impairment is, in the prescribed person's opinion, of a distinctly transient or non-recurrent nature. O. Reg. 38/18, s. 3.

(5) A person prescribed under subsection (1) is not required under subsection 203 (1) of the Act to report modest or incremental changes in ability that, in the prescribed person's opinion, are attributable to a process of natural aging, unless the cumulative effect of the changes constitutes a condition or impairment described in subsection (3). O. Reg. 38/18, s. 3.

(6) When considering whether a person has or appears to have a prescribed medical condition, functional impairment or visual impairment that is described in subsection (3), a prescribed person under subsection (1) may take into consideration,

(a) the CCMTA Medical Standards for Drivers described in subsection 14 (4); and

(b) the document entitled Determining Medical Fitness to Operate Motor Vehicles (9th edition), published by the Canadian Medical Association and dated 2017, as it may be amended from time to time, that is available on the Internet through the website of the Canadian Medical Association. O. Reg. 38/18, s. 3.

14.2 For the purposes of subsection 203 (2) of the Act, the following are the prescribed persons who may report under that subsection: an occupational therapist, an optometrist, a nurse practitioner and a physician. O. Reg. 38/18, s. 3.

15. (1) An examination of an applicant for or a holder of any class of driver's licence, including a driver's licence with or without any endorsement, condition or waiver, or an examination in relation to any endorsement, condition or waiver may include,

(a) an examination of the person's knowledge of the Act and the regulations under it;

(b) a demonstration of the person's ability to drive safely a motor vehicle of a class authorized to be driven by the class of licence applied for or held;

(c) a demonstration of the person's ability to operate safely a motor vehicle of a class authorized to be driven by the class of licence applied for and that is equipped with air brakes, or a combination of such a motor vehicle and towed vehicles;

(d) an examination of a person's knowledge of air brakes, their functions and safe operation for the class of licence applied for or held; and

(e) medical and physical examinations, tests and procedures to determine the person's fitness to drive or to determine whether the person meets the qualifications prescribed by section 14, 17, 18, 21.1 or 21.2. O. Reg. 340/94, s. 15 (1); O. Reg. 490/98, s. 1; O. Reg. 83/05, s. 8 (1, 2); O. Reg. 42/12, s. 2.

(1.1) It is a condition of a driver's licence that the holder submit to the examinations required under subsection (1) at such times as the Minister may require. O. Reg. 83/05, s. 8 (3).

(2) An examination under subsection (1) may include the applicable level 2 exit test in the case of a person fully licensed to operate a Class G or M motor vehicle or in the case of an applicant for a Class G or M driver's licence or a driving instructor's licence. O. Reg. 340/94, s. 15 (2).

(3) The applicable level 2 exit test may be taken in a Class G motor vehicle, including one equipped with air brakes, in the case of any person fully licensed to operate a Class G vehicle. O. Reg. 340/94, s. 15 (3); O. Reg. 205/10, s. 8.

(4) If an examination referred to in this section includes a demonstration of the person's ability to drive safely a motor vehicle, the applicant shall be deemed to be fully licensed in that class of vehicle for the purpose of the examination. O. Reg. 340/94, s. 15 (4).

(5) Revoked: O. Reg. 38/18, s. 4.

16. The Minister may require that,

(a) any holder of a Class G or M driver's licence who has reached the age of 80 complete successfully the applicable examinations prescribed in section 15 every two years and demonstrate every two years that he or she continues to meet the qualifications prescribed in section 14;

(b) any holder of a driver's licence who has reached the age of 70 and is involved in an accident complete successfully the applicable examinations prescribed in section 15 and demonstrate that he or she continues to meet the qualifications prescribed in section 14;

(c) any holder of a Class A, B, C, D, E or F driver's licence who has reached the age of 65 but has not yet reached the age of 80 and is involved in an accident or accumulates more than two demerit points complete successfully the applicable examinations prescribed in section 15 and demonstrate that he or she continues to meet the qualifications prescribed in section 14;

(d) any holder of a Class A, B, C, D, E or F driver's licence who is under the age of 46 complete successfully the examination prescribed in clause 15 (1) (a) every five years and demonstrate every five years that he or she continues to meet the qualifications prescribed in section 14;

(e) any holder of a Class A, B, C, D, E or F driver's licence who has reached the age of 46 but has not yet reached the age of 65 complete successfully the examination prescribed in clause 15 (1) (a) every five years and demonstrate every three years that he or she continues to meet the qualifications prescribed in section 14;

(f) any holder of a Class A, B, C, D, E or F driver's licence who has reached the age of 65 but has not yet reached the age of 80 complete successfully the examination prescribed in clause 15 (1) (a) every five years and demonstrate every year that he or she continues to meet the qualifications prescribed in section 14;

(g) any holder of a Class D driver's licence who has reached the age of 65 but has not yet reached the age of 80 complete successfully the examination prescribed in clause 15 (1) (a) every five years and demonstrate every five years that he or she continues to meet the qualifications prescribed in subsection 18 (3);

Note: On July 1, 2018, clause 16 (g) of the Regulation is revoked. (See: O. Reg. 100/17, s. 1 (4))

(h) any holder of a Class A, B, C, D, E or F driver's licence who has reached the age of 80 complete successfully the applicable examinations prescribed in section 15 every year and demonstrate every year that he or she continues to meet the qualifications prescribed in section 14; and

(i) any holder of a driver's licence with an air brake endorsement complete successfully the examinations prescribed in clauses 15 (1) (c) and (d),

(i) at any time that he or she is required under any of clauses (a) to (h) to take an examination prescribed in clause 15 (1) (a) or (b), or

(ii) every five years. O. Reg. 251/12, s. 2.

17. An applicant for or a holder of a Class B, C, E or F driver's licence whose hearing in one ear is better than in the other must be able to perceive in the better ear, with or without a hearing aid, a forced whisper at a distance of 1.5 metres or, if an audiometer is used to test the person's hearing, must not have a loss in the better ear of more than 40 decibels at 500, 1,000 and 2,000 hertz. O. Reg. 453/10, s. 3.

18. (1) An applicant for or a holder of a Class M, M1 or M2 driver's licence must have,

(a) a visual acuity as measured by Snellen Rating that is not poorer than 20/50, with both eyes open and examined together with or without the aid of corrective lenses; and

(b) a horizontal visual field of at least 120 continuous degrees along the horizontal meridian and at least 15 continuous degrees above and below fixation, with both eyes open and examined together. O. Reg. 83/05, s. 10.

(2) An applicant for or a holder of a Class G, G1 or G2 driver's licence must have,

(a) a visual acuity as measured by Snellen Rating that is not poorer than 20/50 with both eyes open and examined together with or without the aid of corrective lenses; and

(b) a horizontal visual field of at least 120 continuous degrees along the horizontal meridian and at least 15 continuous degrees above and below fixation, with both eyes open and examined together. O. Reg. 83/05, s. 10.

(3) An applicant for or a holder of a Class A, B, C, D, E or F driver's licence must

have,

(a) a visual acuity as measured by Snellen Rating that is not poorer than 20/30 with both eyes open and examined together and not poorer than 20/100 in the weaker eye, with or without the aid of corrective lenses; and
(b) a horizontal visual field of at least 150 continuous degrees along the horizontal meridian and at least 20 continuous degrees above and below fixation, with both eyes open and examined together. O. Reg. 453/10, s. 4.

(4) Where the horizontal visual field of a driver is to be determined,

(a) it shall be measured without the aid of extraordinary optical devices that enhance or modify vision or that interfere with the horizontal visual field, such as telescopic lenses, prism lenses or sidebar prisms;

(b) the continuous horizontal visual field shall not include the natural blind spot;

(c) the visual field representation must include the central visual fixation point at its centre;

(d) no less than half of the continuous degrees of the horizontal visual field that are required along the horizontal meridian shall be found on either side of the vertical meridian; and

(e) the continuous degrees of the horizontal visual field that are required above and below fixation shall be continuous throughout the required continuous degrees along the horizontal meridian. O. Reg. 38/18, s. 5.

19. The examinations and qualifications required of an applicant for or a holder of a driver's licence by sections 14, 16 and 17, subsection 18 (1), clause 18 (2) (a), subsections 18 (3) and (4) and sections 21.1 and 21.2 apply despite the Human Rights Code. O. Reg. 453/10, s. 5; O. Reg. 38/18, s. 6.

20. If the Minister waived under this section any of the qualifications set out in section 17, as this section and section 17 read before January 1, 2011, with respect to an applicant for or a holder of any class of driver's licence, the Minister may renew the waiver of those qualifications for the holder requesting a renewal of his or her licence, as if those qualifications still applied to the holder, if,

(a) the holder provides evidence satisfactory to the Minister, including the reports of any examinations which the Minister may require, that he or she can safely drive motor vehicles in the class authorized to be driven by the class of licence for which a renewal has been applied; and

(b) there has been no worsening of the condition that would have disqualified the holder had the waiver not been granted. O. Reg. 453/10, s. 6.

21. Revoked: O. Reg. 453/10, s. 7.

21.1 If the Minister waived under this section a qualification set out in clause 17 (1) (j) or (k), as this section and as those clauses read before January 1, 2011, for an applicant for or a holder of a Class A or D driver's licence, the Minister may renew the waiver of the qualification set out in clause 18 (3) (a) or (b), as applicable, for the holder requesting a renewal of his or her licence if,

(a) the holder can safely drive motor vehicles in the class authorized to be driven by the class of licence for which a renewal is requested;

(b) there is no worsening of the condition that would have disqualified the holder had the prior waiver not been granted;

(c) the holder provides evidence that he or she has successfully completed the tests, procedures and examinations that the Minister may require to demonstrate that the conditions in clauses (a) and (b) are satisfied; and

(d) the holder does not have a medical condition or disability that requires a Ministerial waiver from the qualifications for obtaining any class of driver's licence prescribed in the Act or the regulations other than the waiver under this section. O. Reg. 83/05, s. 12 (4); O. Reg. 453/10, s. 8.

21.2 (1) The Minister may waive the qualification set out in clause 18 (2) (b) for an applicant for or a holder of a Class G, G1 or G2 driver's licence if,

(a) the applicant or holder provides evidence that he or she has successfully completed the tests, procedures and examinations that the Minister may require; and

(b) the applicant or holder,

(i) meets all of the other qualifications set out in this Regulation for the applicable class of driver's licence,

(ii) has not been able to meet the qualification set out in clause 18 (2) (b) for a period of at least three months immediately before the application,

(iii) does not have a medical or visual condition or disability that, alone or combined with a reduced horizontal visual field, may significantly impair his or her ability to drive, including,

(A) a neurological deficit or disorder, including epilepsy,

(B) diabetes that requires insulin for control,

(C) hypotension, or

(D) an impairment resulting from dementia, stroke, brain tumour, brain surgery, head trauma or arthritis,

(iv) does not have accumulated more than six demerit points on his or her driving record,

(v) did not have his or her driver's licence under suspension at any time within the preceding five years pursuant to section 53, subsection 128

(15) or section 130, 172, 200 or 216 of the Act or as a result of a conviction under the Criminal Code(Canada) for an offence committed by means of a motor vehicle or while driving or having the care, charge or control of a motor vehicle, and

(vi) has not, within the preceding five years and within the period of time he or she has been unable to meet the requirements of clause 18 (2) (b), been involved in a collision the circumstances of which also gave rise to a conviction for contravening or failing to comply with section 128, 136, 138, 140, 141, 147, 148, 154, 156, 158 or 172 or subsection 175 (11) of the Act. O. Reg. 83/05, s. 13.

(2) The Minister may revoke a waiver given under subsection (1) at any time if the holder no longer meets the requirements of subclause (1) (b) (i), (iii), (iv), (v) or (vi). O. Reg. 83/05, s. 13.

(3) If the applicant's or holder's horizontal visual field is so fragmented or incomplete that the size, shape, nature or relative position of the defects in it or along the horizontal meridian or above or below fixation may significantly impair his or her ability to drive, then the Minister shall not grant the waiver under this section. O. Reg. 83/05, s. 13.

Personal Health Information Protection Act

In 2004, new federal privacy legislation (*Personal Information Protection and Electronic Documents Act* [PIPEDA]) came into force to address issues around the handling of personal information. In November 2005, Ontario's *Personal Health Information Protection Act* (PHIPA), which contains provisions for the collection, use and disclosure of personal health information, was declared "substantially similar" to PIPEDA. As a result, healthcare practitioners in Ontario look to PHIPA for guidance with regard to management of the information in their patient health records.

Patients have a right to access their health information. An optometrist cannot refuse to provide this access to a patient except in very specific circumstances, such as the information was collected as part of an investigation.

Optometrists, as health information custodians, are expected to have practice policies in place that protect patient privacy. These policies should cover:

- measures taken to protect personal health information;
- storage/retention and destruction of personal information; and
- access to personal information.

PHIPA is enforced by the Information and Privacy Commissioner. The Commissioner has advised all health information custodians in Ontario that they should never store any personal health information on their laptops or mobile computing devices unless they have taken strong steps (such as encryption) to ensure that the information is protected against unauthorized access if the device is lost or stolen. Where personal health information must be stored on portable electronic devices, only the minimal amount of information necessary should be stored, and for the least amount of time necessary to complete the required work. Most important, where personal health information is stored on mobile devices in identifiable form, the information must be encrypted.

One of the differences between PIPEDA and PHIPA is that PHIPA does not require the practitioner to obtain a patient's written or verbal consent every time information is collected, used or disclosed. It can be assumed that there is implied consent when information is exchanged among the 'circle of care' of healthcare professionals providing care to the patient, as long as the exchange of information is for the purpose of providing direct health care and the patient has not expressly withheld or withdrawn consent. Express consent is still required if a practitioner wishes to share personal health information outside the circle of care. It is important to note that a practitioner may send patient health information to the College for a practice assessment by the Quality Assurance Committee, or for an Inquiries, Complaints and Reports Committee investigation.

While it is not necessary to obtain a patient's signed consent to perform routine optometric procedures, it may be prudent to obtain signed consent if, for example, the patient has agreed to be part of a study (such as a contact lens study). Patients provide implied consent by the simple act of making an appointment and coming to the optometrist's office for an eye examination. They understand that information will need to be collected and certain procedures will be performed.

If a practitioner becomes aware that a breach of privacy has occurred (a fax was sent to the wrong destination, a computer with patient information has been stolen, etc.), there are a number of steps to be followed:

- ensure all office staff members are notified immediately that a breach has occurred
- identify the scope of the breach and take steps to contain it
- identify those patients whose privacy was breached, notify them of the breach and advise them of the steps that have been or will be taken to address the breach, both immediate and long term.

If a breach occurs, it may be appropriate for the practitioner to review their general office procedures. Staff must be educated and trained with respect to compliance with PHIPA.

Personal Health Information Protection Act, 2004

S.O. 2004, CHAPTER 3
Schedule A

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PART I
INTERPRETATION AND APPLICATION

PURPOSES, DEFINITIONS AND INTERPRETATION

Purposes

1. The purposes of this Act are,

(a) to establish rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care;

(b) to provide individuals with a right of access to personal health information about themselves, subject to limited and specific exceptions set out in this Act;

(c) to provide individuals with a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions set out in this Act;

(d) to provide for independent review and resolution of complaints with respect to personal health information; and

(e) to provide effective remedies for contraventions of this Act. 2004, c. 3, Sched. A, s. 1.

Definitions

2. In this Act,

"agent", in relation to a health information custodian, means a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated; ("mandataire")

"Assistant Commissioner" means the Assistant Commissioner for Personal Health Information appointed under the *Freedom of Information and Protection of Privacy Act*; ("commissaire adjoint")

"attorney for personal care" means an attorney under a power of attorney for personal care made in accordance with the *Substitute Decisions Act, 1992*; ("procureur au soin de la personne")

"attorney for property" means an attorney under a continuing power of attorney for property made in accordance with the *Substitute Decisions Act, 1992*; ("procureur aux biens")

"Board" means the Consent and Capacity Board constituted under the *Health Care Consent Act, 1996*; ("Commission")

"capable" means mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité")

"collect", in relation to personal health information, means to gather, acquire, receive or obtain the information by any means from any source, and "collection" has a corresponding meaning; ("recueillir", "collecte")

"Commissioner" means the Information and Privacy Commissioner appointed under the *Freedom of Information and Protection of Privacy Act*; ("commissaire")

"disclose", in relation to personal health information in the custody or under the control of a health information custodian or a person, means to make the information available or to release it to another health information custodian or to another person, but does not include to use the information, and "disclosure" has a corresponding meaning; ("divulguer", "divulgation")

"guardian of property" means a guardian of property or a statutory guardian of property under the *Substitute Decisions Act, 1992*; ("tuteur aux biens")

"guardian of the person" means a guardian of the person appointed under the *Substitute Decisions Act, 1992*; ("tuteur à la personne")

"health care" means any observation, examination, assessment, care, service or procedure that is done for a health-related purpose and that,

(a) is carried out or provided to diagnose, treat or maintain an individual's physical or mental condition,

(b) is carried out or provided to prevent disease or injury or to promote health, or

(c) is carried out or provided as part of palliative care,

and includes,

(d) the compounding, dispensing or selling of a drug, a device, equipment or any other item to an individual, or for the use of an individual, pursuant to a prescription, and

(e) a community service that is described in subsection 2 (3) of the *Long-Term Care Act, 1994* and provided by a service provider within the meaning of that Act; ("soins de santé")

"health care practitioner" means,

(a) a person who is a member within the meaning of the *Regulated Health Professions Act, 1991* and who provides health care,

(b) a person who is registered as a drugless practitioner under the *Drugless Practitioners Act* and who provides health care,

(c) a person who is a member of the Ontario College of Social Workers and Social Service Workers and who provides health care, or

(d) any other person whose primary function is to provide health care for payment; ("praticien de la santé")

"health information custodian" has the meaning set out in section 3; ("dépositaire de renseignements sur la santé")

"health number" means the number, the version code or both of them assigned to an insured person within the meaning of the *Health Insurance Act* by the General Manager within the meaning of that Act; ("numéro de la carte Santé")

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning; ("incapable", "incapacité")

"individual", in relation to personal health information, means the individual, whether living or deceased, with respect to whom the information was or is being collected or created; ("particulier")

"information practices", in relation to a health information custodian, means the policy of the custodian for actions in relation to personal health information, including,

(a) when, how and the purposes for which the custodian routinely collects, uses, modifies, discloses, retains or disposes of personal health information, and

(b) the administrative, technical and physical safeguards and practices that the custodian maintains with respect to the information; ("pratiques relatives aux renseignements")

"Minister" means the Minister of Health and Long-Term Care; ("ministre")

"partner" means either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives; ("partenaire")

"person" includes a partnership, association or other entity; ("personne")

"personal health information" has the meaning set out in section 4; ("renseignements personnels sur la santé")

"prescribed" means prescribed by the regulations made under this Act; ("prescrit")

"proceeding" includes a proceeding held in, before or under the rules of a court, a tribunal, a commission, a justice of the peace, a coroner, a committee of a College within the meaning of the *Regulated Health Professions Act, 1991*, a committee of the Board of Regents continued under the *Drugless Practitioners Act*, a committee of the Ontario College of Social Workers and Social Service Workers under the *Social Work and Social Service Work Act, 1998*, an arbitrator or a mediator; ("instance")

"quality of care information" has the same meaning as in the *Quality of Care Information Protection Act, 2004*; ("renseignements sur la qualité des soins")

"record" means a record of information in any form or in any medium, whether in written, printed, photographic or electronic form or otherwise, but does not include a computer program or other mechanism that can produce a record; ("dossier")

"relative" means either of two persons who are related to each other by blood, marriage or adoption; ("parent")

"research" means a systematic investigation designed to develop or establish principles, facts or generalizable knowledge, or any combination of them, and includes the development, testing and evaluation of research; ("recherche")

"researcher" means a person who conducts research; ("chercheur")

"research ethics board" means a board of persons that is established for the purpose of approving research plans under section 44 and that meets the prescribed requirements; ("commission d'éthique de la recherche")

"spouse" means either of two persons who,

(a) are married to each other, or

(b) live together in a conjugal relationship outside marriage and,

(i) have cohabited for at least one year,
(ii) are together the parents of a child, or
(iii) have together entered into a cohabitation agreement under section 53 of the *Family Law Act*,

unless they are living separate and apart as a result of a breakdown of their relationship; ("conjoint")

"substitute decision-maker" has the meaning set out in section 5; ("mandataire spécial")

"use", in relation to personal health information in the custody or under the control of a health information custodian or a person, means to handle or deal with the information, subject to subsection 6 (1), but does not include to disclose the information, and "use", as a noun, has a corresponding meaning. ("utiliser", "utilisation") 2004, c. 3, Sched. A, s. 2.

Health information custodian

3. (1) In this Act,

"health information custodian", subject to subsections (3) to (11), means a person or organization described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties or the work described in the paragraph, if any:

1. A health care practitioner or a person who operates a group practice of health care practitioners.
2. A service provider within the meaning of the *Long-Term Care Act, 1994* who provides a community service to which that Act applies.
3. A community care access corporation within the meaning of the *Community Care Access Corporations Act, 2001*.
4. A person who operates one of the following facilities, programs or services:
    i. A hospital within the meaning of the *Public Hospitals Act*, a private hospital within the meaning of the *Private Hospitals Act*, a psychiatric facility within the meaning of the *Mental Health Act*, an institution within

the meaning of the *Mental Hospitals Act* or an independent health facility within the meaning of the *Independent Health Facilities Act*.

ii. An approved charitable home for the aged within the meaning of the *Charitable Institutions Act*, a placement co-ordinator described in subsection 9.6 (2) of that Act, a home or joint home within the meaning of the *Homes for the Aged and Rest Homes Act*, a placement co-ordinator described in subsection 18 (2) of that Act, a nursing home within the meaning of the *Nursing Homes Act*, a placement co-ordinator described in subsection 20.1 (2) of that Act or a care home within the meaning of the *Tenant Protection Act, 1997*.

iii. A pharmacy within the meaning of Part VI of the *Drug and Pharmacies Regulation Act*.

iv. A laboratory or a specimen collection centre as defined in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act*.

v. An ambulance service within the meaning of the *Ambulance Act*.

vi. A home for special care within the meaning of the *Homes for Special Care Act*.

vii. A centre, program or service for community health or mental health whose primary purpose is the provision of health care.

5. An evaluator within the meaning of the *Health Care Consent Act, 1996* or an assessor within the meaning of the *Substitute Decisions Act, 1992*.
6. A medical officer of health or a board of health within the meaning of the *Health Protection and Promotion Act*.
7. The Minister, together with the Ministry of the Minister if the context so requires.
8. Any other person prescribed as a health information custodian if the person has custody or control of personal health information as a result of or in connection with performing prescribed powers, duties or work or any prescribed class of such persons. 2004, c. 3, Sched. A, s. 3 (1).

Interpretation, officer in charge

(2) For the purposes of subparagraph 4 i of the definition of "health information custodian" in subsection (1), the officer in charge of an institution within the meaning of the *Mental Hospitals Act* shall be deemed to be the person who operates the institution. 2004, c. 3, Sched. A, s. 3 (2).

Exceptions

(3) Except as is prescribed, a person described in any of the following paragraphs is not a health information custodian in respect of personal health information that the person collects, uses or discloses while performing the person's powers or duties or the work described in the paragraph, if any:

1. A person described in paragraph 1, 2 or 5 of the definition of "health information custodian" in subsection (1) who is an agent of a health information custodian.

2. A person who is authorized to act for or on behalf of a person that is not a health information custodian, if the scope of duties of the authorized person does not include the provision of health care.
3. The Minister when acting on behalf of an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* that is not a health information custodian. 2004, c. 3, Sched. A, s. 3 (3).

Other exceptions

(4) A health information custodian does not include a person described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the work described in the paragraph:

1. An aboriginal healer who provides traditional healing services to aboriginal persons or members of an aboriginal community.
2. An aboriginal midwife who provides traditional midwifery services to aboriginal persons or members of an aboriginal community.
3. A person who treats another person solely by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment. 2004, c. 3, Sched. A, s. 3 (4).

Multiple facilities

(5) Subject to subsection (6) or an order of the Minister under subsection (8), a health information custodian that operates more than one facility described in one of the subparagraphs of paragraph 4 of the definition of "health information custodian" in subsection (1) shall be deemed to be a separate custodian with respect to personal health information of which it has custody or control as a result of or in connection with operating each of the facilities that it operates. 2004, c. 3, Sched. A, s. 3 (5).

Single custodian

(6) Despite subsection (5), the following persons shall be deemed to be a single health information custodian with respect to all the functions described in the applicable paragraph, if any:

1. A person who operates a hospital within the meaning of the *Public Hospitals Act* and any of the facilities, programs or services described in paragraph 4 of the definition of "health information custodian" in subsection (1).
2. A community care access corporation that provides a community service within the meaning of subsection 2 (3) of the *Long Term Care Act, 1994* and acts as a placement co-ordinator as described in subsection 9.6 (2) of the *Charitable Institutions Act*, subsection 18 (2) of the *Homes for the Aged and Rest Homes Act* or subsection 20.1 (2) of the *Nursing Homes Act*.
3. Health information custodians or facilities that are prescribed. 2004, c. 3, Sched. A, s. 3 (6).

Application to act as one custodian

(7) A health information custodian that operates more than one facility described in one of the subparagraphs of paragraph 4 of the definition of "health information custodian" in subsection (1) or two or more health information custodians may apply to the Minister, in a form approved by the Minister, for an order described in subsection (8). 2004, c. 3, Sched. A, s. 3 (7).

Minister's order

(8) Upon receiving an application described in subsection (7), the Minister may make an order permitting all or some of the applicants to act as a single health information custodian on behalf of those facilities, powers, duties or work that the Minister specifies, subject to the terms that the Minister considers appropriate and specifies in the order, if the Minister is of the opinion that it is appropriate to make the order in the circumstances, having regard to,

(a) the public interest;

(b) the ability of the applicants to provide individuals with reasonable access to their personal health information;

(c) the ability of the applicants to comply with the requirements of this Act; and

(d) whether permitting the applicants to act as a single health information custodian is necessary to enable them to effectively provide integrated health care. 2004, c. 3, Sched. A, s. 3 (8).

Scope of order

(9) In an order made under subsection (8), the Minister may order that any class of health information custodians that the Minister considers to be situated similarly to the applicants is permitted to act as a single health information custodian, subject to the terms that the Minister considers appropriate and specifies in the order, if the Minister is of the opinion that it is appropriate to so order, having regard to,

(a) the public interest;

(b) the ability of the custodians that are subject to the order made under this subsection to provide individuals with reasonable access to their personal health information;

(c) the ability of the custodians that are subject to the order made under this subsection to comply with the requirements of this Act; and

(d) whether permitting the custodians that are subject to the order made under this subsection to act as a single health information custodian is necessary to enable them to effectively provide integrated health care. 2004, c. 3, Sched. A, s. 3 (9).

No hearing required

(10) The Minister is not required to hold a hearing or to afford to any person an opportunity for a hearing before making an order under subsection (8). 2004, c. 3, Sched. A, s. 3 (10).

Duration

(11) Subject to subsection (12), a health information custodian does not cease to be a health information custodian with respect to a record of personal health information until complete custody and control of the record, where applicable, passes to another person who is legally authorized to hold the record. 2004, c. 3, Sched. A, s. 3 (11).

Death of custodian

(12) If a health information custodian dies, the following person shall be deemed to be the health information custodian with respect to records of personal health information held by the deceased custodian until custody and control of the records, where applicable, passes to another person who is legally authorized to hold the records:

1. The estate trustee of the deceased custodian.
2. The person who has assumed responsibility for the administration of the deceased custodian's estate, if the estate does not have an estate trustee. 2004, c. 3, Sched. A, s. 3 (12).

Personal health information

4. (1) In this Act,

"personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,

(a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,

(b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,

(c) is a plan of service within the meaning of the *Long-Term Care Act, 1994* for the individual,

(d) relates to payments or eligibility for health care in respect of the individual,

(e) relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,

(f) is the individual's health number, or

(g) identifies an individual's substitute decision-maker. 2004, c. 3, Sched. A, s. 4 (1).

Identifying information

(2) In this section,

"identifying information" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized,

either alone or with other information, to identify an individual. 2004, c. 3, Sched. A, s. 4 (2).

Mixed records

(3) Personal health information about an individual includes identifying information about the individual that is not personal health information described in subsection (1) but that is contained in a record that contains personal health information described in that subsection about the individual. 2004, c. 3, Sched. A, s. 4 (3).

Exception

(4) Personal health information does not include identifying information contained in a record that is in the custody or under the control of a health information custodian if,

(a) the identifying information contained in the record relates primarily to one or more employees or other agents of the custodian; and

(b) the record is maintained primarily for a purpose other than the provision of health care or assistance in providing health care to the employees or other agents. 2004, c. 3, Sched. A, s. 4 (4).

Substitute decision-maker

5. (1) In this Act,

"substitute decision-maker", in relation to an individual, means, unless the context requires otherwise, a person who is authorized under this Act to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual. 2004, c. 3, Sched. A, s. 5 (1).

Decision about treatment

(2) A substitute decision-maker of an individual within the meaning of section 9 of the *Health Care Consent Act, 1996* shall be deemed to be a substitute decision-maker of the individual in respect of the collection, use or disclosure of personal health information about the individual if the purpose of the collection, use or disclosure is necessary for, or ancillary to, a decision about a treatment under Part II of that Act. 2004, c. 3, Sched. A, s. 5 (2).

Admission to a care facility

(3) A substitute decision-maker of an individual within the meaning of section 39 of the *Health Care Consent Act, 1996* shall be deemed to be a substitute decision-maker of the individual in respect of the collection, use or disclosure of personal health information about the individual if the purpose of the collection, use or disclosure is necessary for, or ancillary to, a decision about admission to a care facility under Part III of that Act. 2004, c. 3, Sched. A, s. 5 (3).

Personal assistance services

(4) A substitute decision-maker of an individual within the meaning of section 56 of the *Health Care Consent Act, 1996* shall be deemed to be a substitute

decision-maker of the individual in respect of the collection, use or disclosure of personal health information about the individual if the purpose of the collection, use or disclosure is necessary for, or ancillary to, a decision about a personal assistance service under Part IV of that Act. 2004, c. 3, Sched. A, s. 5 (4).

Interpretation

6. (1) For the purposes of this Act, the providing of personal health information between a health information custodian and an agent of the custodian is a use by the custodian, and not a disclosure by the person providing the information or a collection by the person to whom the information is provided. 2004, c. 3, Sched. A, s. 6 (1).

Provisions based on consent

(2) A provision of this Act that applies to the collection, use or disclosure of personal health information about an individual by a health information custodian with the consent of the individual, whatever the nature of the consent, does not affect the collection, use or disclosure that this Act permits or requires the health information custodian to make of the information
without the consent of the individual. 2004, c. 3, Sched. A, s. 6 (2).

Permissive disclosure

(3) A provision of this Act that permits a health information custodian to disclose personal health information about an individual without the consent of the individual,

(a) does not require the custodian to disclose it unless required to do so by law;
(b) does not relieve the custodian from a legal requirement to disclose the information; and
(c) does not prevent the custodian from obtaining the individual's consent for the disclosure. 2004, c. 3, Sched. A, s. 6 (3).

APPLICATION OF ACT

Application of Act

7. (1) Except if this Act or its regulations specifically provide otherwise, this Act applies to,

(a) the collection of personal health information by a health information custodian on or after the day this section comes into force;
(b) the use or disclosure of personal health information, on or after the day this section comes into force, by,
    (i) a health information custodian, even if the custodian collected the information before that day, or
    (ii) a person who is not a health information custodian and to whom a health information custodian disclosed the information, even if the person received the information before that day; and
(c) the collection, use or disclosure of a health number by any person on or after the day this section comes into force. 2004, c. 3, Sched. A, s. 7 (1).

Conflict

(2) In the event of a conflict between a provision of this Act or its regulations and a provision of any other Act or its regulations, this Act and its regulations prevail unless this Act, its regulations or the other Act specifically provide otherwise. 2004, c. 3, Sched. A, s. 7 (2).

Interpretation

(3) For the purpose of this section, there is no conflict unless it is not possible to comply with both this Act and its regulations and any other Act or its regulations. 2004, c. 3, Sched. A, s. 7 (3).

Exception

(4) This Act and its regulations do not prevail in the event of a conflict between a provision of this Act or its regulations and a provision of the *Quality of Care Information Protection Act, 2004* or its regulations. 2004, c. 3, Sched. A, s. 7 (4).

Freedom of information legislation

8. (1) Subject to subsection (2), the *Freedom of Information and Protection of Privacy Act* and the *Municipal Freedom of Information and Protection of Privacy Act* do not apply to personal health information collected by a health information custodian or in the custody or under the control of a health information custodian unless this Act specifies otherwise. 2004, c. 3, Sched. A, s. 8 (1).

Exceptions

(2) Sections 11, 12, 15, 16, 17 and 33, subsection 35 (2) and sections 36 and 44 of the *Freedom of Information and Protection of Privacy Act* and sections 5, 9, 10, 24, 25, 26 and 34 of the *Municipal Freedom of Information and Protection of Privacy Act* apply in respect of records of personal health information in the custody or under the control of a health information custodian that is an institution within the meaning of either of those Acts, as the case may be, or that is acting as part of such an institution. 2004, c. 3, Sched. A, s. 8 (2).

Same

(3) A record of personal health information prepared by or in the custody or control of an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* shall be deemed to be a record to which clause 32 (b) of the *Freedom of Information and Protection of Privacy Act* or clause 25 (1) (b) of the *Municipal Freedom of Information and Protection of Privacy Act* applies, as the case may be. 2004, c. 3, Sched. A, s. 8 (3).

Access

(4) This Act does not limit a person's right of access under section 10 of the *Freedom of Information and Protection of Privacy Act* or section 4 of the *Municipal Freedom of Information and Protection of Privacy Act* to a record of

personal health information if all the types of information referred to in subsection 4 (1) are reasonably severed from the record. 2004, c. 3, Sched. A, s. 8 (4).

Transition

(5) This Act does not apply to a collection, use or disclosure of personal health information, a request for access or an appeal made under the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* before the day this section comes into force, and the applicable Act continues to apply to the collection, use, disclosure, request or appeal. 2004, c. 3, Sched. A, s. 8 (5).

Non-application of Act

9. (1) This Act does not apply to personal health information about an individual after the earlier of 120 years after a record containing the information was created and 50 years after the death of the individual. 2004, c. 3, Sched. A, s. 9 (1).

Other rights and Acts

(2) Nothing in this Act shall be construed to interfere with,

(a) anything in connection with a subrogated claim or a potential subrogated claim;

(b) any legal privilege, including solicitor-client privilege;

(c) the law of evidence or information otherwise available by law to a party or a witness in a proceeding;

(d) the power of a court or a tribunal to compel a witness to testify or to compel the production of a document;

(e) the regulatory activities of a College under the *Regulated Heath Professions Act, 1991*, the College under the *Social Work and Social Service Work Act, 1998* or the Board under the *Drugless Practitioners Act*; or

(f) any provision of any Act of Ontario or Canada or any court order, if the provision or order, as the case may be, prohibits a person from making information public or from publishing information. 2004, c. 3, Sched. A, s. 9 (2).

PART II
PRACTICES TO PROTECT PERSONAL HEALTH INFORMATION

GENERAL

Information practices

10. (1) A health information custodian that has custody or control of personal health information shall have in place information practices that comply with the requirements of this Act and its regulations. 2004, c. 3, Sched. A, s. 10 (1).

Duty to follow practices

(2) A health information custodian shall comply with its information practices. 2004, c. 3, Sched. A, s. 10 (2).

Use of electronic means

(3) A health information custodian that uses electronic means to collect, use, modify, disclose, retain or dispose of personal health information shall comply with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 10 (3).

Providers to custodians

(4) A person who provides goods or services for the purpose of enabling a health information custodian to use electronic means to collect, use, modify, disclose, retain or dispose of personal health information shall comply with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 10 (4).

Accuracy

11. (1) A health information custodian that uses personal health information about an individual shall take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes for which it uses the information. 2004, c. 3, Sched. A, s. 11 (1).

Same, disclosure

(2) A health information custodian that discloses personal health information about an individual shall,

(a) take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes of the disclosure that are known to the custodian at the time of the disclosure; or

(b) clearly set out for the recipient of the disclosure the limitations, if any, on the accuracy, completeness or up-to-date character of the information. 2004, c. 3, Sched. A, s. 11 (2).

Security

12. (1) A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian's custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal. 2004, c. 3, Sched. A, s. 12 (1).

Notice of loss, etc.

(2) Subject to subsection (3) and subject to the exceptions and additional requirements, if any, that are prescribed, a health information custodian that has custody or control of personal health information about an individual shall notify the individual at the first reasonable opportunity if the information is stolen, lost, or accessed by unauthorized persons. 2004, c. 3, Sched. A, s. 12 (2).

Exception

(3) If the health information custodian is a researcher who has received the personal health information from another health information custodian under subsection 44 (1), the researcher shall not notify the individual that the information is stolen, lost or accessed by unauthorized persons unless the health information custodian under that subsection first obtains the individual's consent to having the researcher contact the individual and informs the researcher that the individual has given the consent. 2004, c. 3, Sched. A, s. 12 (3).

RECORDS

Handling of records

13. (1) A health information custodian shall ensure that the records of personal health information that it has in its custody or under its control are retained, transferred and disposed of in a secure manner and in accordance with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 13 (1).

Retention of records subject to a request

(2) Despite subsection (1), a health information custodian that has custody or control of personal health information that is the subject of a request for access under section 53 shall retain the information for as long as necessary to allow the individual to exhaust any recourse under this Act that he or she may have with respect to the request. 2004, c. 3, Sched. A, s. 13 (2).

Place where records kept

14. (1) A health information custodian may keep a record of personal health information about an individual in the individual's home in any reasonable manner to which the individual consents, subject to any restrictions set out in a regulation, by-law or published guideline under the *Regulated Health Professions Act, 1991*, an Act referred to in Schedule 1 of that Act, the *Drugless Practitioners Act* or the *Social Work and Social Service Work Act, 1998*. 2004, c. 3, Sched. A, s. 14 (1).

Records kept in other places

(2) A health care practitioner may keep a record of personal health information about an individual in a place other than the individual's home and other than a place in the control of the practitioner if,

(a) the record is kept in a reasonable manner;

(b) the individual consents;

(c) the health care practitioner is permitted to keep the record in the place in accordance with a regulation, by-law or published guideline under the *Regulated Health Professions Act, 1991*, an Act referred to in Schedule 1 to that Act, the *Drugless Practitioners Act* or the *Social Work and Social Service Work Act, 1998*, if the health care practitioner is described in any of clauses (a) to (c) of the definition of "health care practitioner" in section 2; and

(d) the prescribed conditions, if any, are satisfied. 2004, c. 3, Sched. A, s. 14 (2).

ACCOUNTABILITY AND OPENNESS

Contact person

15. (1) A health information custodian that is a natural person may designate a contact person described in subsection (3). 2004, c. 3, Sched. A, s. 15 (1).

Same

(2) A health information custodian that is not a natural person shall designate a contact person described in subsection (3). 2004, c. 3, Sched. A, s. 15 (2).

Functions of contact person

(3) A contact person is an agent of the health information custodian and is authorized on behalf of the custodian to,

(a) facilitate the custodian's compliance with this Act;

(b) ensure that all agents of the custodian are appropriately informed of their duties under this Act;

(c) respond to inquiries from the public about the custodian's information practices;

(d) respond to requests of an individual for access to or correction of a record of personal health information about the individual that is in the custody or under the control of the custodian; and

(e) receive complaints from the public about the custodian's alleged contravention of this Act or its regulations. 2004, c. 3, Sched. A, s. 15 (3).

If no contact person

(4) A health information custodian that is a natural person and that does not designate a contact person under subsection (1) shall perform on his or her own the functions described in clauses (3) (b), (c), (d) and (e). 2004, c. 3, Sched. A, s. 15 (4).

Written public statement

16. (1) A health information custodian shall, in a manner that is practical in the circumstances, make available to the public a written statement that,

(a) provides a general description of the custodian's information practices;

(b) describes how to contact,

(i) the contact person described in subsection 15 (3), if the custodian has one, or

(ii) the custodian, if the custodian does not have that contact person;

(c) describes how an individual may obtain access to or request correction of a record of personal health information about the individual that is in the custody or control of the custodian; and

(d) describes how to make a complaint to the custodian and to the Commissioner under this Act. 2004, c. 3, Sched. A, s. 16 (1).

Notification

(2) If a health information custodian uses or discloses personal health information about an individual, without the individual's consent, in a manner that is outside the scope of the custodian's description of its information practices under clause (1) (a), the custodian shall,

(a) inform the individual of the uses and disclosures at the first reasonable opportunity unless, under section 52, the individual does not have a right of access to a record of the information;
(b) make a note of the uses and disclosures; and
(c) keep the note as part of the records of personal health information about the individual that it has in its custody or under its control or in a form that is linked to those records. 2004, c. 3, Sched. A, s. 16 (2).

Agents and information

17. (1) A health information custodian is responsible for personal health information in the custody or control of the health information custodian and may permit the custodian's agents to collect, use, disclose, retain or dispose of personal health information on the custodian's behalf only if,

(a) the custodian is permitted or required to collect, use, disclose, retain or dispose of the information, as the case may be;
(b) the collection, use, disclosure, retention or disposition of the information, as the case may be, is in the course of the agent's duties and not contrary to the limits imposed by the custodian, this Act or another law; and
(c) the prescribed requirements, if any, are met. 2004, c. 3, Sched. A, s. 17 (1).

Restriction on agents

(2) Except as permitted or required by law and subject to the exceptions and additional requirements, if any, that are prescribed, an agent of a health information custodian shall not collect, use, disclose, retain or dispose of personal health information on the custodian's behalf unless the custodian permits the agent to do so in accordance with subsection (1). 2004, c. 3, Sched. A, s. 17 (2).

Responsibility of agent

(3) An agent of a health information custodian shall notify the custodian at the first reasonable opportunity if personal health information handled by the agent on behalf of the custodian is stolen, lost or accessed by unauthorized persons. 2004, c. 3, Sched. A, s. 17 (3).

PART III
CONSENT CONCERNING PERSONAL HEALTH INFORMATION

GENERAL

Elements of consent

18. (1) If this Act or any other Act requires the consent of an individual for the collection, use or disclosure of personal health information by a health information custodian, the consent,

(a) must be a consent of the individual;
(b) must be knowledgeable;
(c) must relate to the information; and
(d) must not be obtained through deception or coercion. 2004, c. 3, Sched. A, s. 18 (1).

Implied consent

(2) Subject to subsection (3), a consent to the collection, use or disclosure of personal health information about an individual may be express or implied. 2004, c. 3, Sched. A, s. 18 (2).

Exception

(3) A consent to the disclosure of personal health information about an individual must be express, and not implied, if,

(a) a health information custodian makes the disclosure to a person that is not a health information custodian; or
(b) a health information custodian makes the disclosure to another health information custodian and the disclosure is not for the purposes of providing health care or assisting in providing health care. 2004, c. 3, Sched. A, s. 18 (3).

Same

(4) Subsection (3) does not apply to,

(a) a disclosure pursuant to an implied consent described in subsection 20 (4);
(b) a disclosure pursuant to clause 32 (1) (b); or
(c) a prescribed type of disclosure that does not include information about an individual's state of health. 2004, c. 3, Sched. A, s. 18 (4).

Knowledgeable consent

(5) A consent to the collection, use or disclosure of personal health information about an individual is knowledgeable if it is reasonable in the circumstances to believe that the individual knows,

(a) the purposes of the collection, use or disclosure, as the case may be; and
(b) that the individual may give or withhold consent. 2004, c. 3, Sched. A, s. 18 (5).

Notice of purposes

(6) Unless it is not reasonable in the circumstances, it is reasonable to believe that an individual knows the purposes of the collection, use or disclosure of personal health information about the individual by a health information custodian if the custodian posts or makes readily available a notice describing the purposes where it is likely to come to the individual's attention or provides the individual with such a notice. 2004, c. 3, Sched. A, s. 18 (6).

Transition

(7) A consent that an individual gives, before the day that subsection (1) comes into force, to a collection, use or disclosure of information that is personal health information is a valid consent if it meets the requirements of this Act for consent. 2004, c. 3, Sched. A, s. 18 (7).

Withdrawal of consent

19. (1) If an individual consents to have a health information custodian collect, use or disclose personal health information about the individual, the individual may withdraw the consent, whether the consent is express or implied, by providing notice to the health information custodian, but the withdrawal of the consent shall not have retroactive effect. 2004, c. 3, Sched. A, s. 19 (1).

Conditional consent

(2) If an individual places a condition on his or her consent to have a health information custodian collect, use or disclose personal health information about the individual, the condition is not effective to the extent that it purports to prohibit or restrict any recording of personal health information by a health information custodian that is required by law or by established standards of professional practice or institutional practice. 2004, c. 3, Sched. A, s. 19 (2).

Assumption of validity

20. (1) A health information custodian who has obtained an individual's consent to a collection, use or disclosure of personal health information about the individual or who has received a copy of a document purporting to record the individual's consent to the collection, use or disclosure is entitled to assume that the consent fulfils the requirements of this Act and the individual has not withdrawn it, unless it is not reasonable to assume so. 2004, c. 3, Sched. A, s. 20 (1).

Implied consent

(2) A health information custodian described in paragraph 1, 2, 3 or 4 of the definition of "health information custodian" in subsection 3 (1), that receives personal health information about an individual from the individual, the individual's substitute decision-maker or another health information custodian for the purpose of providing health care or assisting in the provision of health care to the individual, is entitled to assume that it has the individual's implied consent to collect, use or disclose the information for the purposes of providing health care

or assisting in providing health care to the individual, unless the custodian that receives the information is aware that the individual has expressly withheld or withdrawn the consent. 2004, c. 3, Sched. A, s. 20 (2).

Limited consent

(3) If a health information custodian discloses, with the consent of an individual, personal health information about the individual to a health information custodian described in paragraph 1, 2, 3 or 4 of the definition of "health information custodian" in subsection 3 (1) for the purpose of the provision of health care to the individual and if the disclosing custodian does not have the consent of the individual to disclose all the personal health information about the individual that it considers reasonably necessary for that purpose, the disclosing custodian shall notify the custodian to whom it disclosed the information of that fact. 2004, c. 3, Sched. A, s. 20 (3).

Implied consent, affiliation

(4) If an individual who is a resident or patient in a facility that is a health information custodian provides to the custodian information about his or her religious or other organizational affiliation, the facility may assume that it has the individual's implied consent to provide his or her name and location in the facility to a representative of the religious or other organization, where the custodian has offered the individual the opportunity to withhold or withdraw the consent and the individual has not done so. 2004, c. 3, Sched. A, s. 20 (4).

CAPACITY AND SUBSTITUTE DECISION-MAKING

Capacity to consent

21. (1) An individual is capable of consenting to the collection, use or disclosure of personal health information if the individual is able,

(a) to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure, as the case may be; and

(b) to appreciate the reasonably foreseeable consequences of giving, not giving, withholding or withdrawing the consent. 2004, c. 3, Sched. A, s. 21 (1).

Different information

(2) An individual may be capable of consenting to the collection, use or disclosure of some parts of personal health information, but incapable of consenting with respect to other parts. 2004, c. 3, Sched. A, s. 21 (2).

Different times

(3) An individual may be capable of consenting to the collection, use or disclosure of personal health information at one time, but incapable of consenting at another time. 2004, c. 3, Sched. A, s. 21 (3).

Presumption of capacity

(4) An individual is presumed to be capable of consenting to the collection, use or disclosure of personal health information. 2004, c. 3, Sched. A, s. 21 (4).

Non-application

(5) A health information custodian may rely on the presumption described in subsection (4) unless the custodian has reasonable grounds to believe that the individual is incapable of consenting to the collection, use or disclosure of personal health information. 2004, c. 3, Sched. A, s. 21 (5).

Determination of incapacity

22. (1) A health information custodian that determines the incapacity of an individual to consent to the collection, use or disclosure of personal health information under this Act shall do so in accordance with the requirements and restrictions, if any, that are prescribed. 2004, c. 3, Sched. A, s. 22 (1).

Information about determination

(2) If it is reasonable in the circumstances, a health information custodian shall provide, to an individual determined incapable of consenting to the collection, use or disclosure of his or her personal health information by the custodian, information about the consequences of the determination of incapacity, including the information, if any, that is prescribed. 2004, c. 3, Sched. A, s. 22 (2).

Review of determination

(3) An individual whom a health information custodian determines is incapable of consenting to the collection, use or disclosure of his or her personal health information by a health information custodian may apply to the Board for a review of the determination unless there is a person who is entitled to act as the substitute decision-maker of the individual under subsection 5 (2), (3) or (4). 2004, c. 3, Sched. A, s. 22 (3).

Parties

(4) The parties to the application are:

1. The individual applying for the review of the determination.
2. The health information custodian that has custody or control of the personal health information.
3. All other persons whom the Board specifies. 2004, c. 3, Sched. A, s. 22 (4).

Powers of Board

(5) The Board may confirm the determination of incapacity or may determine that the individual is capable of consenting to the collection, use or disclosure of personal health information. 2004, c. 3, Sched. A, s. 22 (5).

Restriction on repeated applications

(6) If a determination that an individual is incapable with respect to consenting to the collection, use or disclosure of personal health information is confirmed on the final disposition of an application under this section, the individual shall not

make a new application under this section for a determination with respect to the same or a similar issue within six months after the final disposition of the earlier application, unless the Board gives leave in advance. 2004, c. 3, Sched. A, s. 22 (6).

Grounds for leave

(7) The Board may give leave for the new application to be made if it is satisfied that there has been a material change in circumstances that justifies reconsideration of the individual's capacity. 2004, c. 3, Sched. A, s. 22 (7).

Procedure

(8) Sections 73 to 81 of the *Health Care Consent Act, 1996* apply with necessary modifications to an application under this section. 2004, c. 3, Sched. A, s. 22 (8).

Persons who may consent

23. (1) If this Act or any other Act refers to a consent required of an individual to a collection, use or disclosure of personal health information about the individual, a person described in one of the following paragraphs may give, withhold or withdraw the consent:

1. If the individual is capable of consenting to the collection, use or disclosure of the information,
   i. the individual, or
   ii. if the individual is at least 16 years of age, any person who is capable of consenting, whom the individual has authorized in writing to act on his or her behalf and who, if a natural person, is at least 16 years of age.
2. If the individual is a child who is less than 16 years of age, a parent of the child or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent unless the information relates to,
   i. treatment within the meaning of the *Health Care Consent Act, 1996*, about which the child has made a decision on his or her own in accordance with that Act, or
   ii. counselling in which the child has participated on his or her own under the *Child and Family Services Act*.
3. If the individual is incapable of consenting to the collection, use or disclosure of the information, a person who is authorized under subsection 5 (2), (3) or (4) or section 26 to consent on behalf of the individual.
4. If the individual is deceased, the deceased's estate trustee or the person who has assumed responsibility for the administration of the deceased's estate, if the estate does not have an estate trustee.
5. A person whom an Act of Ontario or Canada authorizes or requires to act on behalf of the individual. 2004, c. 3, Sched. A, s. 23 (1).

Definition

(2) In subsection (1),

"parent" does not include a parent who has only a right of access to the child. 2004, c. 3, Sched. A, s. 23 (2).

Conflict if child capable

(3) If the individual is a child who is less than 16 years of age and who is capable of consenting to the collection, use or disclosure of the information and if there is a person who is entitled to act as the substitute decision-maker of the child under paragraph 2 of subsection (1), a decision of the child to give, withhold or withdraw the consent or to provide the information prevails over a conflicting decision of that person. 2004, c. 3, Sched. A, s. 23 (3).

Factors to consider for consent

24. (1) A person who consents under this Act or any other Act on behalf of or in the place of an individual to a collection, use or disclosure of personal health information by a health information custodian, who withholds or withdraws such a consent or who provides an express instruction under clause 37 (1) (a), 38 (1) (a) or 50 (1) (e) shall take into consideration,

(a) the wishes, values and beliefs that,

(i) if the individual is capable, the person knows the individual holds and believes the individual would want reflected in decisions made concerning the individual's personal health information, or

(ii) if the individual is incapable or deceased, the person knows the individual held when capable or alive and believes the individual would have wanted reflected in decisions made concerning the individual's personal health information;

(b) whether the benefits that the person expects from the collection, use or disclosure of the information outweigh the risk of negative consequences occurring as a result of the collection, use or disclosure;

(c) whether the purpose for which the collection, use or disclosure is sought can be accomplished without the collection, use or disclosure; and

(d) whether the collection, use or disclosure is necessary to satisfy any legal obligation. 2004, c. 3, Sched. A, s. 24 (1).

Determination of compliance

(2) If a substitute decision-maker, on behalf of an incapable individual, gives, withholds or withdraws a consent to a collection, use or disclosure of personal health information about the individual by a health information custodian or provides an express instruction under clause 37 (1) (a), 38 (1) (a) or 50 (1) (e) and if the custodian is of the opinion that the substitute decision-maker has not complied with subsection (1), the custodian may apply to the Board for a determination as to whether the substitute decision-maker complied with that subsection. 2004, c. 3, Sched. A, s. 24 (2).

Parties

(3) The parties to the application are:

1. The health information custodian.
2. The incapable individual.
3. The substitute decision-maker.
4. Any other person whom the Board specifies. 2004, c. 3, Sched. A, s. 24 (3).

Power of Board

(4) In determining whether the substitute decision-maker complied with subsection (1), the Board may substitute its opinion for that of the substitute decision-maker. 2004, c. 3, Sched. A, s. 24 (4).

Directions

(5) If the Board determines that the substitute decision-maker did not comply with subsection (1), it may give him or her directions and, in doing so, shall take into consideration the matters set out in clauses (1) (a) to (d). 2004, c. 3, Sched. A, s. 24 (5).

Time for compliance

(6) The Board shall specify the time within which the substitute decision-maker must comply with its directions. 2004, c. 3, Sched. A, s. 24 (6).

Deemed not authorized

(7) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 26 (2). 2004, c. 3, Sched. A, s. 24 (7).

Public Guardian and Trustee

(8) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions and subsection (6) does not apply to him or her. 2004, c. 3, Sched. A, s. 24 (8).

Procedure

(9) Sections 73 to 81 of the *Health Care Consent Act, 1996* apply with necessary modifications to an application under this section. 2004, c. 3, Sched. A, s. 24 (9).

Authority of substitute decision-maker

25. (1) If this Act permits or requires an individual to make a request, give an instruction or take a step and a substitute decision-maker is authorized to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual, the substitute decision-maker may make the request, give the instruction or take the step on behalf of the individual. 2004, c. 3, Sched. A, s. 25 (1).

Same

(2) If a substitute decision-maker makes a request, gives an instruction or takes a step under subsection (1) on behalf of an individual, references in this

Act to the individual with respect to the request made, the instruction given or the step taken by the substitute decision-maker shall be read as references to the substitute decision-maker, and not to the individual. 2004, c. 3, Sched. A, s. 25 (2).

Incapable individual: persons who may consent

26. (1) If an individual is determined to be incapable of consenting to the collection, use or disclosure of personal health information by a health information custodian, a person described in one of the following paragraphs may, on the individual's behalf and in the place of the individual, give, withhold or withdraw the consent:

1. The individual's guardian of the person or guardian of property, if the consent relates to the guardian's authority to make a decision on behalf of the individual.
2. The individual's attorney for personal care or attorney for property, if the consent relates to the attorney's authority to make a decision on behalf of the individual.
3. The individual's representative appointed by the Board under section 27, if the representative has authority to give the consent.
4. The individual's spouse or partner.
5. A child or parent of the individual, or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent. This paragraph does not include a parent who has only a right of access to the individual. If a children's aid society or other person is lawfully entitled to consent in the place of the parent, this paragraph does not include the parent.
6. A parent of the individual with only a right of access to the individual.
7. A brother or sister of the individual.
8. Any other relative of the individual. 2004, c. 3, Sched. A, s. 26 (1).

Requirements

(2) A person described in subsection (1) may consent only if the person,

(a) is capable of consenting to the collection, use or disclosure of personal health information by a health information custodian;

(b) in the case of an individual, is at least 16 years old or is the parent of the individual to whom the personal health information relates;

(c) is not prohibited by court order or separation agreement from having access to the individual to whom the personal health information relates or from giving or refusing consent on the individual's behalf;

(d) is available; and

(e) is willing to assume the responsibility of making a decision on whether or not to consent. 2004, c. 3, Sched. A, s. 26 (2).

Meaning of "available"

(3) For the purpose of clause (2) (d), a person is available if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent. 2004, c. 3, Sched. A, s. 26 (3).

Ranking

(4) A person described in a paragraph of subsection (1) may consent only if no person described in an earlier paragraph meets the requirements of subsection (2). 2004, c. 3, Sched. A, s. 26 (4).

Same

(5) Despite subsection (4), a person described in a paragraph of subsection (1) who is present or has otherwise been contacted may consent if the person believes that,

(a) no other person described in an earlier paragraph or the same paragraph exists; or

(b) although such other person exists, the other person is not a person described in paragraph 1 or 2 of subsection (1) and would not object to the person who is present or has otherwise been contacted making the decision. 2004, c. 3, Sched. A, s. 26 (5).

Public Guardian and Trustee

(6) If no person described in subsection (1) meets the requirements of subsection (2), the Public Guardian and Trustee may make the decision to consent. 2004, c. 3, Sched. A, s. 26 (6).

Conflict between persons in same paragraph

(7) If two or more persons who are described in the same paragraph of subsection (1) and who meet the requirements of subsection (2) disagree about whether to consent, and if their claims rank ahead of all others, the Public Guardian and Trustee may make the decision in their stead. 2004, c. 3, Sched. A, s. 26 (7).

Transition, representative appointed by individual

(8) Where an individual, to whom personal health information relates, appointed a representative under section 36.1 of the *Mental Health Act* before the day this section comes into force, the representative shall be deemed to have the same authority as a person mentioned in paragraph 2 of subsection (1). 2004, c. 3, Sched. A, s. 26 (8).

Limited authority

(9) The authority conferred on the representative by subsection (8) is limited to the purposes for which the representative was appointed. 2004, c. 3, Sched. A, s. 26 (9).

Revocation

(10) An individual who is capable of consenting with respect to personal health information may revoke the appointment mentioned in subsection (8) in writing. 2004, c. 3, Sched. A, s. 26 (10).

Ranking

(11) A person who is entitled to be the substitute decision-maker of the individual under this section may act as the substitute decision-maker only in circumstances where there is no person who may act as the substitute decision-maker of the individual under subsection 5 (2), (3) or (4). 2004, c. 3, Sched. A, s. 26 (11).

Appointment of representative

27. (1) An individual who is 16 years old or older and who is determined to be incapable of consenting to the collection, use or disclosure of personal health information may apply to the Board for appointment of a representative to consent on the individual's behalf to a collection, use or disclosure of the information by a health information custodian. 2004, c. 3, Sched. A, s. 27 (1).

Application by proposed representative

(2) If an individual is incapable of consenting to the collection, use or disclosure of personal health information, another individual who is 16 years old or older may apply to the Board to be appointed as a representative to consent on behalf of the incapable individual to a collection, use or disclosure of the information. 2004, c. 3, Sched. A, s. 27 (2).

Exception

(3) Subsections (1) and (2) do not apply if the individual to whom the personal health information relates has a guardian of the person, a guardian of property, an attorney for personal care, or an attorney for property, who has authority to give or refuse consent to the collection, use or disclosure. 2004, c. 3, Sched. A, s. 27 (3).

Parties

(4) The parties to the application are:

1. The individual to whom the personal health information relates.
2. The proposed representative named in the application.
3. Every person who is described in paragraph 4, 5, 6 or 7 of subsection 26 (1).
4. All other persons whom the Board specifies. 2004, c. 3, Sched. A, s. 27 (4).

Appointment

(5) In an appointment under this section, the Board may authorize the representative to consent, on behalf of the individual to whom the personal health information relates, to,

(a) a particular collection, use or disclosure at a particular time;

(b) a collection, use or disclosure of the type specified by the Board in circumstances specified by the Board, if the individual is determined to be incapable of consenting to the collection, use or disclosure of personal health information at the time the consent is sought; or

(c) any collection, use or disclosure at any time, if the individual is determined to be incapable of consenting to the collection, use or disclosure of personal health information at the time the consent is sought. 2004, c. 3, Sched. A, s. 27 (5).

Criteria for appointment

(6) The Board may make an appointment under this section if it is satisfied that the following requirements are met:

1. The individual to whom the personal health information relates does not object to the appointment.
2. The representative consents to the appointment, is at least 16 years old and is capable of consenting to the collection, use or disclosure of personal health information.
3. The appointment is in the best interests of the individual to whom the personal health information relates. 2004, c. 3, Sched. A, s. 27 (6).

Powers of Board

(7) Unless the individual to whom the personal health information relates objects, the Board may,

(a) appoint as representative a different individual than the one named in the application;

(b) limit the duration of the appointment;

(c) impose any other condition on the appointment; or

(d) on any person's application, remove, vary or suspend a condition imposed on the appointment or impose an additional condition on the appointment. 2004, c. 3, Sched. A, s. 27 (7).

Termination

(8) The Board may, on any person's application, terminate an appointment made under this section if,

(a) the individual to whom the personal health information relates or the representative requests the termination;

(b) the representative is no longer capable of consenting to the collection, use or disclosure of personal health information;

(c) the appointment is no longer in the best interests of the individual to whom the personal health information relates; or

(d) the individual to whom the personal health information relates has a guardian of the person, a guardian of property, an attorney for personal care, or an attorney for property, who has authority to give or refuse consent to the types of collections, uses and disclosures for which the appointment was made and in the circumstances to which the appointment applies. 2004, c. 3, Sched. A, s. 27 (8).

Procedure

(9) Sections 73 to 81 of the *Health Care Consent Act, 1996* apply with necessary modifications to an application under this section. 2004, c. 3, Sched. A, s. 27 (9).

Transition, representative appointed by Board

28. (1) This Act applies to a representative whom the Board appointed under section 36.2 of the *Mental Health Act* or who was deemed to be appointed under that section before the day this section comes into force for an individual with respect to the individual's personal health information, as if the representative were the individual's representative appointed by the Board under section 27. 2004, c. 3, Sched. A, s. 28 (1).

Limited authority

(2) The authority conferred on the representative by subsection (1) is limited to the purposes for which the representative was appointed. 2004, c. 3, Sched. A, s. 28 (2).

PART IV
COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

General Limitations and Requirements

Requirement for consent

29. A health information custodian shall not collect, use or disclose personal health information about an individual unless,

(a) it has the individual's consent under this Act and the collection, use or disclosure, as the case may be, to the best of the custodian's knowledge, is necessary for a lawful purpose; or

(b) the collection, use or disclosure, as the case may be, is permitted or required by this Act. 2004, c. 3, Sched. A, s. 29.

Other information

30. (1) A health information custodian shall not collect, use or disclose personal health information if other information will serve the purpose of the collection, use or disclosure. 2004, c. 3, Sched. A, s. 30 (1).

Extent of information

(2) A health information custodian shall not collect, use or disclose more personal health information than is reasonably necessary to meet the purpose of the collection, use or
disclosure, as the case may be. 2004, c. 3, Sched. A, s. 30 (2).

Exception

(3) This section does not apply to personal health information that a health information custodian is required by law to collect, use or disclose. 2004, c. 3, Sched. A, s. 30 (3).

Use and disclosure of personal health information

31. (1) A health information custodian that collects personal health information in contravention of this Act shall not use it or disclose it unless required by law to do so. 2004, c. 3, Sched. A, s. 31 (1).

Express instruction to public hospitals, etc.

(2) An express instruction that an individual, before November 1, 2005, gives to a health information custodian that is a public hospital within the meaning of the *Public Hospitals Act* or a person described in paragraph 1 of subsection 3 (6) with respect to the use or disclosure of personal health information about the individual is not an express instruction for the purpose of clause 37 (1) (a), 38 (1) (a) or 50 (1) (e). 2004, c. 3, Sched. A, s. 31 (2).

Same

(3) Nothing in subsection (2) prevents the custodian from refraining, in accordance with an express instruction that an individual gives as described in that subsection, to use or disclose the information under clause 37 (1) (a), 38 (1) (a) or 50 (1) (e). 2004, c. 3, Sched. A, s. 31 (3).

Repeal

(4) Subsections (2) and (3) are repealed on November 1, 2005. 2004, c. 3, Sched. A, s. 31 (4).

Fundraising

32. (1) Subject to subsection (2), a health information custodian may collect, use or disclose personal health information about an individual for the purpose of fundraising activities only where,

(a) the individual expressly consents; or

(b) the individual consents by way of an implied consent and the information consists only of the individual's name and the prescribed types of contact information. 2004, c. 3, Sched. A, s. 32 (1).

Requirements and restrictions

(2) The manner in which consent is obtained under subsection (1) and the resulting collection, use or disclosure of personal health information for the purpose of fundraising activities shall comply with the requirements and restrictions that are prescribed, if any. 2004, c. 3, Sched. A, s. 32 (2).

Marketing

33. A health information custodian shall not collect, use or disclose personal health information about an individual for the purpose of marketing anything or for the purpose of market research unless the individual expressly consents and the custodian collects, uses or discloses the information, as the case may be, subject to the prescribed requirements and restrictions, if any. 2004, c. 3, Sched. A, s. 33.

Health cards and health numbers

34. (1) In this section,

"health card" means a card provided to an insured person within the meaning of the *Health Insurance Act* by the General Manager of the Ontario Health Insurance Plan; ("carte Santé")

"provincially funded health resource" means a service, thing, subsidy or other benefit funded, in whole or in part, directly or indirectly by the Government of Ontario, if it is health related or prescribed. ("ressource en matière de santé subventionnée par la province") 2004, c. 3, Sched. A, s. 34 (1).

Collection or use

(2) Despite subsection 49 (1), a person who is not a health information custodian shall not collect or use another person's health number except,

(a) for purposes related to the provision of provincially funded health resources to that other person;

(b) for the purposes for which a health information custodian has disclosed the number to the person;

(c) if the person is the governing body of health care practitioners who provide provincially funded health resources and is collecting or using health numbers for purposes related to its duties or powers; or

(d) if the person is prescribed and is collecting or using the health number, as the case may be, for purposes related to health administration, health planning, health research or epidemiological studies. 2004, c. 3, Sched. A, s. 34 (2).

Disclosure

(3) Despite subsection 49 (1) and subject to the exceptions and additional requirements, if any, that are prescribed, a person who is not a health information custodian shall not disclose a health number except as required by law. 2004, c. 3, Sched. A, s. 34 (3).

Confidentiality of health cards

(4) No person shall require the production of another person's health card, but a person who provides a provincially funded health resource to a person who has a health card may require the production of the health card. 2004, c. 3, Sched. A, s. 34 (4).

Exceptions

(5) Subsections (2) and (3) do not apply to,

(a) a person who collects, uses or discloses a health number for the purposes of a proceeding;

(b) a prescribed entity mentioned in subsection 45 (1) that collects, uses or discloses the health number in the course of carrying out its functions under section 45; or

(c) a health data institute that the Minister approves under subsection 47 (9) and that collects, uses or discloses the health number in the course of carrying out its functions under sections 47 and 48. 2004, c. 3, Sched. A, s. 34 (5).

Fees for personal health information

35. (1) A health information custodian shall not charge a person a fee for collecting or using personal health information except as authorized by the regulations made under this Act. 2004, c. 3, Sched. A, s. 35 (1).

Same, for disclosure

(2) When disclosing personal health information, a health information custodian shall not charge fees to a person that exceed the prescribed amount or the amount of reasonable cost recovery, if no amount is prescribed. 2004, c. 3, Sched. A, s. 35 (2).

COLLECTION

Indirect collection

36. (1) A health information custodian may collect personal health information about an individual indirectly if,

(a) the individual consents to the collection being made indirectly;

(b) the information to be collected is reasonably necessary for providing health care or assisting in providing health care to the individual and it is not reasonably possible to collect, directly from the individual,

(i) personal health information that can reasonably be relied on as accurate, or

(ii) personal health information in a timely manner;

(c) the custodian is an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act*, or is acting as part of such an institution, and the custodian is collecting the information for a purpose related to,

(i) investigating a breach of an agreement or a contravention or an alleged contravention of the laws of Ontario or Canada,

(ii) the conduct of a proceeding or a possible proceeding, or

(iii) the statutory function of the custodian;

(d) the custodian collects the information from a person who is not a health information custodian for the purpose of carrying out research conducted in accordance with subsection 37 (3) or research that a research ethics board has approved under section 44 or that meets the criteria set out in clauses 44 (10) (a) to (c), except if the person is prohibited by law from disclosing the information to the custodian;
(e) the custodian is a prescribed entity mentioned in subsection 45 (1) and the custodian is collecting personal health information from a person who is not a health information custodian for the purpose of that subsection;
(f) the Commissioner authorizes that the collection be made in a manner other than directly from the individual;
(g) the custodian collects the information from a person who is permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada to disclose it to the custodian; or
(h) subject to the requirements and restrictions, if any, that are prescribed, the health information custodian is permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada to collect the information indirectly. 2004, c. 3, Sched. A, s. 36 (1).

Direct collection without consent

(2) A health information custodian may collect personal health information about an individual directly from the individual, even if the individual is incapable of consenting, if the collection is reasonably necessary for the provision of health care and it is not reasonably possible to obtain consent in a timely manner. 2004, c. 3, Sched. A, s. 36 (2).

USE

Permitted use

37. (1) A health information custodian may use personal health information about an individual,

(a) for the purpose for which the information was collected or created and for all the functions reasonably necessary for carrying out that purpose, but not if the information was collected with the consent of the individual or under clause 36 (1) (b) and the individual expressly instructs otherwise;
(b) for a purpose for which this Act, another Act or an Act of Canada permits or requires a person to disclose it to the custodian;
(c) for planning or delivering programs or services that the custodian provides or that the custodian funds in whole or in part, allocating resources to any of them, evaluating or monitoring any of them or detecting, monitoring or preventing fraud or any unauthorized receipt of services or benefits related to any of them;
(d) for the purpose of risk management, error management or for the purpose of activities to improve or maintain the quality of care or to improve or maintain the quality of any related programs or services of the custodian;
(e) for educating agents to provide health care;

(f) in a manner consistent with Part II, for the purpose of disposing of the information or modifying the information in order to conceal the identity of the individual;
(g) for the purpose of seeking the individual's consent, when the personal health information used by the custodian for this purpose is limited to the individual's name and contact information;
(h) for the purpose of a proceeding or contemplated proceeding in which the custodian or the agent or former agent of the custodian is, or is expected to be, a party or witness, if the information relates to or is a matter in issue in the proceeding or contemplated proceeding;
(i) for the purpose of obtaining payment or processing, monitoring, verifying or reimbursing claims for payment for the provision of health care or related goods and services;
(j) for research conducted by the custodian, subject to subsection (3), unless another clause of this subsection applies; or
(k) subject to the requirements and restrictions, if any, that are prescribed, if permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada. 2004, c. 3, Sched. A, s. 37 (1).

Agents

(2) If subsection (1) authorizes a health information custodian to use personal health information for a purpose, the custodian may provide the information to an agent of the custodian who may use it for that purpose on behalf of the custodian. 2004, c. 3, Sched. A, s. 37 (2).

Research

(3) Under clause (1) (j), a health information custodian may use personal health information about an individual only if the custodian prepares a research plan and has a research ethics board approve it and for that purpose subsections 44 (2) to (4) and clauses 44 (6) (a) to (f) apply to the use as if it were a disclosure. 2004, c. 3, Sched. A, s. 37 (3).

Mixed uses

(4) If a research plan mentioned in subsection (3) proposes that a health information custodian that is an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* or that is acting as part of such an institution use personal health information, together with personal information within the meaning of those two Acts that is not personal health information, those two Acts do not apply to the use and this section applies to the use. 2004, c. 3, Sched. A, s. 37 (4).

DISCLOSURE

Disclosures related to providing health care

38. (1) A health information custodian may disclose personal health information about an individual,

(a) to a person described in paragraph 1, 2, 3 or 4 of the definition of "health information custodian" in subsection 3 (1), if the disclosure is reasonably necessary for the provision of health care and it is not reasonably possible to obtain the individual's consent in a timely manner, but not if the individual has expressly instructed the custodian not to make the disclosure;

(b) in order for the Minister or another health information custodian to determine or provide funding or payment to the custodian for the provision of health care; or

(c) for the purpose of contacting a relative, friend or potential substitute decision-maker of the individual, if the individual is injured, incapacitated or ill and unable to give consent personally. 2004, c. 3, Sched. A, s. 38 (1).

Notice of instruction

(2) If a health information custodian discloses personal health information about an individual under clause (1) (a) and if an instruction of the individual made under that clause prevents the custodian from disclosing all the personal health information that the custodian considers reasonably necessary to disclose for the provision of health care or assisting in the provision of health care to the individual, the custodian shall notify the person to whom it makes the disclosure of that fact. 2004, c. 3, Sched. A, s. 38 (2).

Facility that provides health care

(3) A health information custodian that is a facility that provides health care may disclose to a person the following personal health information relating to an individual who is a patient or a resident in the facility if the custodian offers the individual the option, at the first reasonable opportunity after admission to the facility, to object to such disclosures and if the individual does not do so:

1. The fact that the individual is a patient or resident in the facility.
2. The individual's general health status described as critical, poor, fair, stable or satisfactory, or in similar terms.
3. The location of the individual in the facility. 2004, c. 3, Sched. A, s. 38 (3).

Deceased individual

(4) A health information custodian may disclose personal health information about an individual who is deceased, or is reasonably suspected to be deceased,

(a) for the purpose of identifying the individual;

(b) for the purpose of informing any person whom it is reasonable to inform in the circumstances of,

(i) the fact that the individual is deceased or reasonably suspected to be deceased, and

(ii) the circumstances of death, where appropriate; or

(c) to the spouse, partner, sibling or child of the individual if the recipients of the information reasonably require the information to make decisions about their own health care or their children's health care. 2004, c. 3, Sched. A, s. 38 (4).

Disclosures for health or other programs

39. (1) Subject to the requirements and restrictions, if any, that are prescribed, a health information custodian may disclose personal health information about an individual,

(a) for the purpose of determining or verifying the eligibility of the individual to receive health care or related goods, services or benefits provided under an Act of Ontario or Canada and funded in whole or in part by the Government of Ontario or Canada or by a municipality;

(b) to a person conducting an audit or reviewing an application for accreditation or reviewing an accreditation, if the audit or review relates to services provided by the custodian and the person does not remove any records of personal health information from the custodian's premises; or

(c) to a prescribed person who compiles or maintains a registry of personal health information for purposes of facilitating or improving the provision of health care or that relates to the storage or donation of body parts or bodily substances. 2004, c. 3, Sched. A, s. 39 (1).

Same

(2) A health information custodian may disclose personal health information about an individual,

(a) to the Chief Medical Officer of Health or a medical officer of health within the meaning of the *Health Protection and Promotion Act* if the disclosure is made for a purpose of that Act; or

(b) to a public health authority that is similar to the persons described in clause (a) and that is established under the laws of Canada, another province or a territory of Canada or other jurisdiction, if the disclosure is made for a purpose that is substantially similar to a purpose of the *Health Protection and Promotion Act*. 2004, c. 3, Sched. A, s. 39 (2).

Removal allowed

(3) Despite clause (1) (b), the person described in that clause may remove records of personal health information from the custodian's premises if,

(a) the removal is authorized by or under an Act of Ontario or Canada; or

(b) an agreement between the custodian and the person authorizes the removal and provides that the records will be held in a secure and confidential manner and will be returned when the audit or review is completed. 2004, c. 3, Sched. A, s. 39 (3).

Authorization to collect

(4) A person who is not a health information custodian is authorized to collect the personal health information that a health information custodian may disclose to the person under clause (1) (c). 2004, c. 3, Sched. A, s. 39 (4).

Disclosures related to risks

40. (1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. 2004, c. 3, Sched. A, s. 40 (1).

Disclosures related to care or custody

(2) A health information custodian may disclose personal health information about an individual to the head of a penal or other custodial institution in which the individual is being lawfully detained or to the officer in charge of a psychiatric facility within the meaning of the *Mental Health Act* in which the individual is being lawfully detained for the purposes described in subsection (3). 2004, c. 3, Sched. A, s. 40 (2).

Same

(3) A health information custodian may disclose personal health information about an individual under subsection (2) to assist an institution or a facility in making a decision concerning,

(a) arrangements for the provision of health care to the individual; or

(b) the placement of the individual into custody, detention, release, conditional release, discharge or conditional discharge under Part IV of the *Child and Family Services Act*, the *Mental Health Act*, the *Ministry of Correctional Services Act*, the *Corrections and Conditional Release Act* (Canada), Part XX.1 of the *Criminal Code* (Canada), the *Prisons and Reformatories Act* (Canada) or the *Youth Criminal Justice Act* (Canada). 2004, c. 3, Sched. A, s. 40 (3).

Disclosures for proceedings

41. (1) A health information custodian may disclose personal health information about an individual,

(a) subject to the requirements and restrictions, if any, that are prescribed, for the purpose of a proceeding or contemplated proceeding in which the custodian or the agent or former agent of the custodian is, or is expected to be, a party or witness, if the information relates to or is a matter in issue in the proceeding or contemplated proceeding;

(b) to a proposed litigation guardian or legal representative of the individual for the purpose of having the person appointed as such;

(c) to a litigation guardian or legal representative who is authorized under the Rules of Civil Procedure, or by a court order, to commence, defend or

continue a proceeding on behalf of the individual or to represent the individual in a proceeding; or

(d) for the purpose of complying with,

(i) a summons, order or similar requirement issued in a proceeding by a person having jurisdiction to compel the production of information, or

(ii) a procedural rule that relates to the production of information in a proceeding. 2004, c. 3, Sched. A, s. 41 (1).

Disclosure by agent or former agent

(2) An agent or former agent who receives personal health information under subsection (1) or under subsection 37 (2) for purposes of a proceeding or contemplated proceeding may disclose the information to the agent's or former agent's professional advisor for the purpose of providing advice or representation to the agent or former agent, if the advisor is under a professional duty of confidentiality. 2004, c. 3, Sched. A, s. 41 (2).

Disclosure to successor

42. (1) A health information custodian may disclose personal health information about an individual to a potential successor of the custodian, for the purpose of allowing the potential successor to assess and evaluate the operations of the custodian, if the potential successor first enters into an agreement with the custodian to keep the information confidential and secure and not to retain any of the information longer than is necessary for the purpose of the assessment or evaluation. 2004, c. 3, Sched. A, s. 42 (1).

Transfer to successor

(2) A health information custodian may transfer records of personal health information about an individual to the custodian's successor if the custodian makes reasonable efforts to give notice to the individual before transferring the records or, if that is not reasonably possible, as soon as possible after transferring the records. 2004, c. 3, Sched. A, s. 42 (2).

Transfer to archives

(3) Subject to the agreement of the person who is to receive the transfer, a health information custodian may transfer records of personal health information about an individual to,

(a) the Archives of Ontario; or

(b) in the prescribed circumstances, a prescribed person whose functions include the collection and preservation of records of historical or archival importance, if the disclosure is made for the purpose of that function. 2004, c. 3, Sched. A, s. 42 (3).

Disclosures related to this or other Acts

43. (1) A health information custodian may disclose personal health information about an individual,

(a) for the purpose of determining, assessing or confirming capacity under the *Health Care Consent Act, 1996*, the *Substitute Decisions Act, 1992* or this Act;
(b) to a College within the meaning of the *Regulated Health Professions Act, 1991* for the purpose of the administration or enforcement of the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act, 1991* or an Act named in Schedule 1 to that Act;
(c) to the Board of Regents continued under the *Drugless Practitioners Act* for the purpose of the administration or enforcement of that Act;
(d) to the Ontario College of Social Workers and Social Service Workers for the purpose of the administration or enforcement of the *Social Work and Social Service Work Act, 1998*;
(e) to the Public Guardian and Trustee, the Children's Lawyer, a children's aid society, a Residential Placement Advisory Committee established under subsection 34 (2) of the *Child and Family Services Act* or the Registrar of Adoption Information appointed under subsection 163 (1) of that Act so that they can carry out their statutory functions;
(f) in the circumstances described in clause 42 (c), (g) or (n) of the *Freedom of Information and Protection of Privacy Act* or clause 32 (c), (g) or (l) of the *Municipal Freedom of Information and Protection of Privacy Act*, if the custodian is subject to either of those Acts;
(g) subject to the requirements and restrictions, if any, that are prescribed, to a person carrying out an inspection, investigation or similar procedure that is authorized by a warrant or by or under this Act or any other Act of Ontario or an Act of Canada for the purpose of complying with the warrant or for the purpose of facilitating the inspection, investigation or similar procedure;
(h) subject to the requirements and restrictions, if any, that are prescribed, if permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada. 2004, c. 3, Sched. A, s. 43 (1).

Interpretation

(2) For the purposes of clause (1) (h) and subject to the regulations made under this Act, if an Act, an Act of Canada or a regulation made under any of those Acts specifically provides that information is exempt, under stated circumstances, from a confidentiality or secrecy requirement, that provision shall be deemed to permit the disclosure of the information in the stated circumstances. 2004, c. 3, Sched. A, s. 43 (2).

Disclosure for research

44. (1) A health information custodian may disclose personal health information about an individual to a researcher if the researcher,
(a) submits to the custodian,
(i) an application in writing,
(ii) a research plan that meets the requirements of subsection (2), and

(iii) a copy of the decision of a research ethics board that approves the research plan; and

(b) enters into the agreement required by subsection (5). 2004, c. 3, Sched. A, s. 44 (1).

Research plan

(2) A research plan must be in writing and must set out,

(a) the affiliation of each person involved in the research;

(b) the nature and objectives of the research and the public or scientific benefit of the research that the researcher anticipates; and

(c) all other prescribed matters related to the research. 2004, c. 3, Sched. A, s. 44 (2).

Consideration by board

(3) When deciding whether to approve a research plan that a researcher submits to it, a research ethics board shall consider the matters that it considers relevant, including,

(a) whether the objectives of the research can reasonably be accomplished without using the personal health information that is to be disclosed;

(b) whether, at the time the research is conducted, adequate safeguards will be in place to protect the privacy of the individuals whose personal health information is being disclosed and to preserve the confidentiality of the information;

(c) the public interest in conducting the research and the public interest in protecting the privacy of the individuals whose personal health information is being disclosed; and

(d) whether obtaining the consent of the individuals whose personal health information is being disclosed would be impractical. 2004, c. 3, Sched. A, s. 44 (3).

Decision of board

(4) After reviewing a research plan that a researcher has submitted to it, the research ethics board shall provide to the researcher a decision in writing, with reasons, setting out whether the board approves the plan, and whether the approval is subject to any conditions, which must be specified in the decision. 2004, c. 3, Sched. A, s. 44 (4).

Agreement respecting disclosure

(5) Before a health information custodian discloses personal health information to a researcher under subsection (1), the researcher shall enter into an agreement with the custodian in which the researcher agrees to comply with the conditions and restrictions, if any, that the custodian imposes relating to the use, security, disclosure, return or disposal of the information. 2004, c. 3, Sched. A, s. 44 (5).

Compliance by researcher

(6) A researcher who receives personal health information about an individual from a health information custodian under subsection (1) shall,

(a) comply with the conditions, if any, specified by the research ethics board in respect of the research plan;

(b) use the information only for the purposes set out in the research plan as approved by the research ethics board;

(c) not publish the information in a form that could reasonably enable a person to ascertain the identity of the individual;

(d) despite subsection 49 (1), not disclose the information except as required by law and subject to the exceptions and additional requirements, if any, that are prescribed;

(e) not make contact or attempt to make contact with the individual, directly or indirectly, unless the custodian first obtains the individual's consent to being contacted;

(f) notify the custodian immediately in writing if the researcher becomes aware of any breach of this subsection or the agreement described in subsection (5); and

(g) comply with the agreement described in subsection (5). 2004, c. 3, Sched. A, s. 44 (6).

Mixed disclosures

(7) If a researcher submits a research plan under subsection (1) that proposes that a health information custodian that is an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* or that is acting as part of such an institution disclose to the researcher personal health information, together with personal information within the meaning of those two Acts that is not personal health information, those two Acts do not apply to the disclosure and this section applies to the disclosure. 2004, c. 3, Sched. A, s. 44 (7).

Transition

(8) Despite subsection (7), nothing in this section prevents a health information custodian that is an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* or that is acting as part of such an institution from disclosing to a researcher personal health information, that is personal information within the meaning of those two Acts, if, before the day this section comes into force, the researcher has entered into an agreement that requires the custodian to comply with clause 21 (1) (e) of the *Freedom of Information and Protection of Privacy Act* or clause 14 (1) (e) of the *Municipal Freedom of Information and Protection of Privacy Act* as a condition of disclosing the information. 2004, c. 3, Sched. A, s. 44 (8).

Disclosure under other Acts

(9) Despite any other Act that permits a health information custodian to disclose personal health information to a researcher for the purpose of conducting research, this section applies to the disclosure as if it were a disclosure for research under this section unless the regulations made under this Act provide otherwise. 2004, c. 3, Sched. A, s. 44 (9).

Research approved outside Ontario

(10) Subject to subsection (11), a health information custodian may disclose personal health information to a researcher or may use the information to conduct research if,

(a) the research involves the use of personal health information originating wholly or in part outside Ontario;

(b) the research has received the prescribed approval from a body outside Ontario that has the function of approving research; and

(c) the prescribed requirements are met. 2004, c. 3, Sched. A, s. 44 (10).

Same

(11) Subsections (1) to (4) and clauses (6) (a) and (b) do not apply to a disclosure or use made under subsection (10) and references in the rest of this section to subsection (1) shall be read as references to this subsection with respect to that disclosure or use. 2004, c. 3, Sched. A, s. 44 (11).

Transition

(12) Despite anything in this section, a health information custodian that lawfully disclosed personal health information to a researcher for the purpose of conducting research in the three-year period before the day this section comes into force may continue to disclose personal health information to the researcher for the purposes of that research for a period of three years after the day this section comes into force. 2004, c. 3, Sched. A, s. 44 (12).

Same, use

(13) Despite anything in this section, a health information custodian that lawfully used personal health information for the purpose of conducting research in the three-year period before the day this section comes into force may continue to use personal health information for the purposes of that research for a period of three years after the day this section comes into force. 2004, c. 3, Sched. A, s. 44 (13).

Repeal

(14) Subsections (12) and (13) are repealed on the third anniversary of the day they came into force. 2004, c. 3, Sched. A, s. 44 (14).

Note: Subsections (12) and (13) came into force on November 1, 2004. See: 2004, c. 3, Sched. A, s. 99 (2).

Disclosure for planning and management of health system

45. (1) A health information custodian may disclose to a prescribed entity personal health information for the purpose of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of, the allocation of resources to or planning for all or part of the health system, including the delivery of services, if the entity meets the requirements under subsection (3). 2004, c. 3, Sched. A, s. 45 (1).

Exception

(2) Subsection (1) does not apply to,

(a) notes of personal health information about an individual that are recorded by a health information custodian and that document the contents of conversations during a private counselling session or a group, joint or family counselling session; or

(b) prescribed information in circumstances that are prescribed. 2004, c. 3, Sched. A, s. 45 (2).

Approval

(3) A health information custodian may disclose personal health information to a prescribed entity under subsection (1) if,

(a) the entity has in place practices and procedures to protect the privacy of the individuals whose personal health information it receives and to maintain the confidentiality of the information; and

(b) the Commissioner has approved the practices and procedures, if the custodian makes the disclosure on or after the first anniversary of the day this section comes into force. 2004, c. 3, Sched. A, s. 45 (3).

Review by Commissioner

(4) The Commissioner shall review the practices and procedures of each prescribed entity every three years from the date of its approval and advise the health information custodian whether the entity continues to meet the requirements of subsection (3). 2004, c. 3, Sched. A, s. 45 (4).

Authorization to collect

(5) An entity that is not a health information custodian is authorized to collect the personal health information that a health information custodian may disclose to the entity under subsection (1). 2004, c. 3, Sched. A, s. 45 (5).

Use and disclosure

(6) Subject to the exceptions and additional requirements, if any, that are prescribed and despite subsection 49 (1), an entity that receives personal health information under subsection (1) shall not use the information except for the purposes for which it received the information and shall not disclose the information except as required by law. 2004, c. 3, Sched. A, s. 45 (6).

Monitoring health care payments

46. (1) A health information custodian shall, upon the request of the Minister, disclose to the Minister personal health information about an individual for the purpose of monitoring or verifying claims for payment for health care funded wholly or in part by the Ministry of Health and Long-Term Care or for goods used for health care funded wholly or in part by the Ministry of Health and Long-Term Care. 2004, c. 3, Sched. A, s. 46 (1).

Disclosure by Minister

(2) The Minister may disclose information collected under subsection (1) to any person for a purpose set out in that subsection if the disclosure is reasonably necessary for that purpose. 2004, c. 3, Sched. A, s. 46 (2).

Disclosure for analysis of health system

47. (1) In this section,

"de-identify", in relation to the personal health information of an individual, means to remove any information that identifies the individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify the individual, and "de-identification" has a corresponding meaning. 2004, c. 3, Sched. A, s. 47 (1).

Same

(2) Subject to the restrictions, if any, that are prescribed, a health information custodian shall, upon the request of the Minister, disclose personal health information to a health data institute that the Minister approves under subsection (9) for analysis with respect to the management of, evaluation or monitoring of, the allocation of resources to or planning for all or part of the health system, including the delivery of services, if the requirements of this section are met. 2004, c. 3, Sched. A, s. 47 (2).

Form, manner and time of disclosure

(3) The Minister may specify the form and manner in which and the time at which the health information custodian is required to disclose the personal health information under subsection (2). 2004, c. 3, Sched. A, s. 47 (3).

Requirements for Minister

(4) Before requesting the disclosure of personal health information under subsection (2), the Minister shall submit a proposal to the Commissioner and, in accordance with this section, allow the Commissioner to review and comment on the proposal. 2004, c. 3, Sched. A, s. 47 (4).

Contents of proposal

(5) The proposal must identify a health data institute to which the personal health information would be disclosed under this section and must set out the prescribed matters. 2004, c. 3, Sched. A, s. 47 (5).

Review by Commissioner

(6) Within 30 days after the Commissioner receives the proposal, the Commissioner shall review the proposal and may comment in writing on the proposal. 2004, c. 3, Sched. A, s. 47 (6).

Consideration by Commissioner

(7) In reviewing the proposal, the Commissioner shall consider the public interest in conducting the analysis and the privacy interest of the individuals to whom the personal health information relates in the circumstances. 2004, c. 3, Sched. A, s. 47 (7).

Consideration by Minister

(8) The Minister shall consider the comments, if any, made by the Commissioner within the time specified in subsection (6), and may amend the proposal if the Minister considers it appropriate. 2004, c. 3, Sched. A, s. 47 (8).

Approval of health data institute

(9) The Minister may approve a health data institute for the purposes of a disclosure made under this section if,

(a) the corporate objects of the institute include performing data analysis of personal health information, linking the information with other information and de-identifying the information for the Minister; and

(b) the institute has in place practices and procedures to protect the privacy of the individuals whose personal health information it receives and to maintain the confidentiality of the information and the Commissioner has approved those practices and procedures. 2004, c. 3, Sched. A, s. 47 (9).

Review by Commissioner

(10) The Commissioner shall review the practices and procedures of each health data institute every three years from the date of its approval and advise the Minister whether the institute continues to meet the requirements of clauses (9) (a) and (b). 2004, c. 3, Sched. A, s. 47 (10).

Withdrawal of approval

(11) The Minister shall withdraw the approval of a health data institute that ceases to meet the requirements of clauses (9) (a) and (b) or to carry out its objects mentioned in clause (9) (a), unless the Minister requires the institute to take immediate steps to satisfy the Minister that it will meet the requirements or that it will carry out the objects. 2004, c. 3, Sched. A, s. 47 (11).

Effect of withdrawal of approval

(12) If the Minister withdraws the approval of a health data institute, the institute shall,

(a) make no further use or disclosure of any personal health information that a health information custodian has disclosed to it under subsection (2) or any information derived from that personal health information; and
(b) comply with the written directions of the Minister that the Commissioner has approved in writing with respect to information described in clause (a). 2004, c. 3, Sched. A, s. 47 (12).

If institute ceases to exist

(13) If a health data institute ceases to exist, the persons holding the personal health information that the institute received under subsection (2) and held when it ceased to exist shall comply with the written directions of the Minister that the Commissioner has approved in writing with respect to the information. 2004, c. 3, Sched. A, s. 47 (13).

Disclosure by Minister

(14) The Minister may disclose to the health data institute that receives personal health information under subsection (2) other personal health information for the purposes of the analysis and linking that the Minister requires if the disclosure is included in the Minister's proposal, as amended under subsection (8), if applicable. 2004, c. 3, Sched. A, s. 47 (14).

Duties of health data institute

(15) A health data institute that receives personal health information under subsection (2) or (14) shall,
(a) follow the practices and procedures described in clause (9) (b) that the Commissioner has approved;
(b) perform the analysis and linking with other data that the Minister requires;
(c) de-identify the information;
(d) provide the results of the analysis and linking, using only de-identified information, to the Minister or to the persons that the Minister approves;
(e) not disclose the information to the Minister or to the persons that the Minister approves except in a de-identified form; and
(f) subject to clauses (d) and (e), not disclose to any persons the information, even in a de-identified form, or any information derived from the information. 2004, c. 3, Sched. A, s. 47 (15).

Transition

(16) If the Minister has lawfully required the disclosure of personal health information for a purpose described in subsection (2) in the 18 months before this section comes into force, this section does not apply with respect to a disclosure the Minister requires for a substantially similar purpose after this section comes into force until the first anniversary of the coming into force of this section. 2004, c. 3, Sched. A, s. 47 (16).

Notification

(17) If the Minister requires a disclosure for a substantially similar purpose under subsection (16) after this section comes into force, the Minister shall notify

the Commissioner within the later of the time of requiring the disclosure and 90 days after this section comes into force. 2004, c. 3, Sched. A, s. 47 (17).

No hearing required

(18) The Minister is not required to hold a hearing or to afford to any person an opportunity for a hearing before making a decision under this section. 2004, c. 3, Sched. A, s. 47 (18).

Disclosure with Commissioner's approval

48. (1) A health data institute to which a health information custodian has disclosed personal health information under section 47, shall, upon the request of the Minister and in accordance with the Commissioner's approval given under this section, disclose the information to the Minister or another person approved by the Minister if the Minister is of the opinion that it is in the public interest to request the disclosure and the requirements of this section have been met. 2004, c. 3, Sched. A, s. 48 (1).

Non-application of section

(2) The personal health information mentioned in subsection (1) is not,

(a) notes of personal health information about an individual that are recorded by a health information custodian and that document the contents of conversations during a private counselling session or a group, joint or family counselling session; or

(b) information that is prescribed. 2004, c. 3, Sched. A, s. 48 (2).

Commissioner's approval required

(3) The Minister shall not request the disclosure of personal health information under subsection (1) unless the Minister has submitted to the Commissioner a proposal for the disclosure and the Commissioner has approved the proposal. 2004, c. 3, Sched. A, s. 48 (3).

Contents of proposal

(4) The proposal must include,

(a) a statement as to why the disclosure is reasonably required in the public interest and why the disclosure under section 47 was insufficient to meet the public interest;

(b) the extent of the identifiers that the Minister proposes be part of the information disclosed and a statement as to why the use of those identifiers is reasonably required for the purpose of the disclosure;

(c) a copy of all proposals and comments previously made or received under section 47 in respect of the information, if any; and

(d) all other information that the Commissioner requires. 2004, c. 3, Sched. A, s. 48 (4).

Terms of approval

(5) If the Commissioner approves the proposal, the Commissioner may specify terms, conditions or limitations for the disclosure. 2004, c. 3, Sched. A, s. 48 (5).

Restrictions on recipients

49. (1) Except as permitted or required by law and subject to the exceptions and additional requirements, if any, that are prescribed, a person who is not a health information custodian and to whom a health information custodian discloses personal health information, shall not use or disclose the information for any purpose other than,

(a) the purpose for which the custodian was authorized to disclose the information under this Act; or

(b) the purpose of carrying out a statutory or legal duty. 2004, c. 3, Sched. A, s. 49 (1).

Extent of use or disclosure

(2) Subject to the exceptions and additional requirements, if any, that are prescribed, a person who is not a health information custodian, and to whom a health information custodian discloses personal health information, shall not use or disclose more of the information than is reasonably necessary to meet the purpose of the use or disclosure, as the case may be, unless the use or disclosure is required by law. 2004, c. 3, Sched. A, s. 49 (2).

Employee or agent information

(3) Except as permitted or required by law and subject to the exceptions and additional requirements, if any, that are prescribed, if a health information custodian discloses information to another health information custodian and the information is identifying information of the type described in subsection 4 (4) in the custody or under the control of the receiving custodian, the receiving custodian shall not,

(a) use or disclose the information for any purpose other than,

(i) the purpose for which the disclosing custodian was authorized to disclose the information under this Act, or

(ii) the purpose of carrying out a statutory or legal duty; or

(b) use or disclose more of the information than is reasonably necessary to meet the purpose of the use or disclosure, as the case may be. 2004, c. 3, Sched. A, s. 49 (3).

Same

(4) The restrictions set out in clauses (3) (a) and (b) apply to a health information custodian that receives the identifying information described in subsection (3) even if the custodian receives the information before the day that subsection comes into force. 2004, c. 3, Sched. A, s. 49 (4).

Freedom of information legislation

(5) Except as prescribed, this section does not apply to an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* that is not a health information custodian. 2004, c. 3, Sched. A, s. 49 (5).

Disclosure outside Ontario

50. (1) A health information custodian may disclose personal health information about an individual collected in Ontario to a person outside Ontario only if,

(a) the individual consents to the disclosure;

(b) this Act permits the disclosure;

(c) the person receiving the information performs functions comparable to the functions performed by a person to whom this Act would permit the custodian to disclose the information in Ontario under subsection 40 (2) or clause 43 (1) (b), (c), (d) or (e);

(d) the following conditions are met:

(i) the custodian is a prescribed entity mentioned in subsection 45 (1) and is prescribed for the purpose of this clause,

(ii) the disclosure is for the purpose of health planning or health administration,

(iii) the information relates to health care provided in Ontario to a person who is resident of another province or territory of Canada, and

(iv) the disclosure is made to the government of that province or territory;

(e) the disclosure is reasonably necessary for the provision of health care to the individual, but not if the individual has expressly instructed the custodian not to make the disclosure; or

(f) the disclosure is reasonably necessary for the administration of payments in connection with the provision of health care to the individual or for contractual or legal requirements in that connection. 2004, c. 3, Sched. A, s. 50 (1).

Notice of instruction

(2) If a health information custodian discloses personal health information about an individual under clause (1) (e) and if an instruction of the individual made under that clause prevents the custodian from disclosing all the personal health information that the custodian considers reasonably necessary to disclose for the provision of health care to the individual, the custodian shall notify the person to whom it makes the disclosure of that fact. 2004, c. 3, Sched. A, s. 50 (2).

PART V
ACCESS TO RECORDS OF PERSONAL HEALTH INFORMATION AND CORRECTION

ACCESS

Application of Part

51. (1) This Part does not apply to a record that contains,

(a) quality of care information;

(b) personal health information collected or created for the purpose of complying with the requirements of a quality assurance program within the meaning of the Health Professions Procedural Code that is Schedule 2 to the *Regulated Health Professions Act, 1991*;

(c) raw data from standardized psychological tests or assessments; or

(d) personal health information of the prescribed type in the custody or under the control of a prescribed class or classes of health information custodians. 2004, c. 3, Sched. A, s. 51 (1).

Severable record

(2) Despite subsection (1), this Part applies to that part of a record of personal health information that can reasonably be severed from the part of the record that contains the information described in clauses (1) (a) to (d). 2004, c. 3, Sched. A, s. 51 (2).

Agent of a non-custodian

(3) This Part does not apply to a record in the custody or under the control of a health information custodian acting as an agent of an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* that is not a health information custodian if the individual has the right to request access to the record under one of those Acts. 2004, c. 3, Sched. A, s. 51 (3).

Individual's right of access

52. (1) Subject to this Part, an individual has a right of access to a record of personal health information about the individual that is in the custody or under the control of a health information custodian unless,

(a) the record or the information in the record is subject to a legal privilege that restricts disclosure of the record or the information, as the case may be, to the individual;

(b) another Act, an Act of Canada or a court order prohibits disclosure to the individual of the record or the information in the record in the circumstances;

(c) the information in the record was collected or created primarily in anticipation of or use in a proceeding, and the proceeding, together with all appeals or processes resulting from it, have not been concluded;

(d) the following conditions are met:

(i) the information was collected or created in the course of an inspection, investigation or similar procedure authorized by law, or undertaken for the purpose of the detection, monitoring or prevention of a person's receiving or attempting to receive a service or benefit, to which the person is not entitled under an Act or a program operated by the Minister, or a payment for such a service or benefit, and

(ii) the inspection, investigation, or similar procedure, together with all proceedings, appeals or processes resulting from them, have not been concluded;

(e) granting the access could reasonably be expected to,

(i) result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious bodily harm to the individual or another person,

(ii) lead to the identification of a person who was required by law to provide information in the record to the custodian, or

(iii) lead to the identification of a person who provided information in the record to the custodian explicitly or implicitly in confidence if the custodian considers it appropriate in the circumstances that the name of the person be kept confidential; or

(f) the following conditions are met:

(i) the custodian is an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* or is acting as part of such an institution, and

(ii) the custodian would refuse to grant access to the part of the record,

(A) under clause 49 (a), (c) or (e) of the *Freedom of Information and Protection of Privacy Act*, if the request were made under that Act and that Act applied to the record, or

(B) under clause 38 (a) or (c) of the *Municipal Freedom of Information and Protection of Privacy Act*, if the request were made under that Act and that Act applied to the record. 2004, c. 3, Sched. A, s. 52 (1).

Severable record

(2) Despite subsection (1), an individual has a right of access to that part of a record of personal health information about the individual that can reasonably be severed from the part of the record to which the individual does not have a right of access as a result of clauses (1) (a) to (f). 2004, c. 3, Sched. A, s. 52 (2).

Same

(3) Despite subsection (1), if a record is not a record dedicated primarily to personal health information about the individual requesting access, the individual has a right of access only to the portion of personal health information about the individual in the record that can reasonably be severed from the record for the purpose of providing access. 2004, c. 3, Sched. A, s. 52 (3).

Individual's plan of service

(4) Despite subsection (1), a health information custodian shall not refuse to grant the individual access to his or her plan of service within the meaning of the *Long-Term Care Act, 1994*. 2004, c. 3, Sched. A, s. 52 (4).

Consultation regarding harm

(5) Before deciding to refuse to grant an individual access to a record of personal health information under subclause (1) (e) (i), a health information custodian may consult with a member of the College of Physicians and Surgeons of Ontario or a member of the College of Psychologists of Ontario. 2004, c. 3, Sched. A, s. 52 (5).

Informal access

(6) Nothing in this Act prevents a health information custodian from,

(a) granting an individual access to a record of personal health information, to which the individual has a right of access, if the individual makes an oral request for access or does not make any request for access under section 53; or

(b) with respect to a record of personal health information to which an individual has a right of access, communicating with the individual or his or her substitute decision-maker who is authorized to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual. 2004, c. 3, Sched. A, s. 52 (6).

Duty of health information custodian

(7) Nothing in this Part relieves a health information custodian from a legal duty to provide, in a manner that is not inconsistent with this Act, personal health information as expeditiously as is necessary for the provision of health care to the individual. 2004, c. 3, Sched. A, s. 52 (7).

Request for access

53. (1) An individual may exercise a right of access to a record of personal health information by making a written request for access to the health information custodian that has custody or control of the information. 2004, c. 3, Sched. A, s. 53 (1).

Detail in request

(2) The request must contain sufficient detail to enable the health information custodian to identify and locate the record with reasonable efforts. 2004, c. 3, Sched. A, s. 53 (2).

Assistance

(3) If the request does not contain sufficient detail to enable the health information custodian to identify and locate the record with reasonable efforts, the custodian shall offer assistance to the person requesting access in reformulating the request to comply with subsection (2). 2004, c. 3, Sched. A, s. 53 (3).

Response of health information custodian

54. (1) A health information custodian that receives a request from an individual for access to a record of personal health information shall,

(a) make the record available to the individual for examination and, at the request of the individual, provide a copy of the record to the individual and if reasonably practical, an explanation of any term, code or abbreviation used in the record;

(b) give a written notice to the individual stating that, after a reasonable search, the custodian has concluded that the record does not exist or cannot be found, if that is the case;

(c) if the custodian is entitled to refuse the request, in whole or in part, under any provision of this Part other than clause 52 (1) (c), (d) or (e), give a written notice to the individual stating that the custodian is refusing the request, in whole or in part, providing a reason for the refusal and stating that the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI; or

(d) if the custodian is entitled to refuse the request, in whole or in part, under clause 52 (1) (c), (d) or (e), give a written notice to the individual stating that the custodian is refusing to confirm or deny the existence of any record subject to any of those provisions and that the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI. 2004, c. 3, Sched. A, s. 54 (1).

Time for response

(2) Subject to subsection (3), the health information custodian shall give the response required by clause (1) (a), (b), (c) or (d) as soon as possible in the circumstances but no later than 30 days after receiving the request. 2004, c. 3, Sched. A, s. 54 (2).

Extension of time for response

(3) Within 30 days after receiving the request for access, the health information custodian may extend the time limit set out in subsection (2) for a further period of time of not more than 30 days if,

(a) meeting the time limit would unreasonably interfere with the operations of the custodian because the information consists of numerous pieces of information or locating the information would necessitate a lengthy search; or
(b) the time required to undertake the consultations necessary to reply to the request within 30 days after receiving it would make it not reasonably practical to reply within that time. 2004, c. 3, Sched. A, s. 54 (3).

Notice of extension

(4) Upon extending the time limit under subsection (3), the health information custodian shall give the individual written notice of the extension setting out the length of the extension and the reason for the extension. 2004, c. 3, Sched. A, s. 54 (4).

Expedited access

(5) Despite subsection (2), the health information custodian shall give the response required by clause (1) (a), (b), (c) or (d) within the time period that the individual specifies if,
(a) the individual provides the custodian with evidence satisfactory to the custodian, acting on a reasonable basis, that the individual requires access to the requested record of personal health information on an urgent basis within that time period; and
(b) the custodian is reasonably able to give the required response within that time period. 2004, c. 3, Sched. A, s. 54 (5).

Frivolous or vexatious requests

(6) A health information custodian that believes on reasonable grounds that a request for access to a record of personal health information is frivolous or vexatious or is made in bad faith may refuse to grant the individual access to the requested record. 2004, c. 3, Sched. A, s. 54 (6).

Effect of non-compliance

(7) If the health information custodian does not respond to the request within the time limit or before the extension, if any, expires, the custodian shall be deemed to have refused the individual's request for access. 2004, c. 3, Sched. A, s. 54 (7).

Right to complain

(8) If the health information custodian refuses or is deemed to have refused the request, in whole or in part,
(a) the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI; and
(b) in the complaint, the burden of proof in respect of the refusal lies on the health information custodian. 2004, c. 3, Sched. A, s. 54 (8).

Identity of individual

(9) A health information custodian shall not make a record of personal health information or a part of it available to an individual under this Part or provide a copy of it to an individual under clause (1) (a) without first taking reasonable steps to be satisfied as to the individual's identity. 2004, c. 3, Sched. A, s. 54 (9).

Fee for access

(10) A health information custodian that makes a record of personal health information or a part of it available to an individual under this Part or provides a copy of it to an individual under clause (1) (a) may charge the individual a fee for that purpose if the custodian first gives the individual an estimate of the fee. 2004, c. 3, Sched. A, s. 54 (10).

Amount of fee

(11) The amount of the fee shall not exceed the prescribed amount or the amount of reasonable cost recovery, if no amount is prescribed. 2004, c. 3, Sched. A, s. 54 (11).

Waiver of fee

(12) A health information custodian mentioned in subsection (10) may waive the payment of all or any part of the fee that an individual is required to pay under that subsection if, in the custodian's opinion, it is fair and equitable to do so. 2004, c. 3, Sched. A, s. 54 (12).

CORRECTION

Correction

55. (1) If a health information custodian has granted an individual access to a record of his or her personal health information and if the individual believes that the record is inaccurate or incomplete for the purposes for which the custodian has collected or used the information, the individual may request in writing that the custodian correct the record. 2004, c. 3, Sched. A, s. 55 (1).

Informal request

(2) If the individual makes an oral request that the health information custodian correct the record, nothing in this Part prevents the custodian from making the requested correction. 2004, c. 3, Sched. A, s. 55 (2).

Reply

(3) As soon as possible in the circumstances but no later than 30 days after receiving a request for a correction under subsection (1), the health information custodian shall, by written notice to the individual, grant or refuse the individual's request or extend the deadline for replying for a period of not more than 30 days if,

(a) replying to the request within 30 days would unreasonably interfere with the activities of the custodian; or

(b) the time required to undertake the consultations necessary to reply to the request within 30 days would make it not reasonably practical to reply within that time. 2004, c. 3, Sched. A, s. 55 (3).

Extension of time for reply

(4) A health information custodian that extends the time limit under subsection (3) shall,

(a) give the individual written notice of the extension setting out the length of the extension and the reason for the extension; and

(b) grant or refuse the individual's request as soon as possible in the circumstances but no later than the expiry of the time limit as extended. 2004, c. 3, Sched. A, s. 55 (4).

Deemed refusal

(5) A health information custodian that does not grant a request for a correction under subsection (1) within the time required shall be deemed to have refused the request. 2004, c. 3, Sched. A, s. 55 (5).

Frivolous or vexatious requests

(6) A health information custodian that believes on reasonable grounds that a request for a correction under subsection (1) is frivolous or vexatious or is made in bad faith may refuse to grant the request and, in that case, shall provide the individual with a notice that sets out the reasons for the refusal and that states that the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI. 2004, c. 3, Sched. A, s. 55 (6).

Right to complain

(7) The individual is entitled to make a complaint to the Commissioner under Part VI about a refusal made under subsection (6). 2004, c. 3, Sched. A, s. 55 (7).

Duty to correct

(8) The health information custodian shall grant a request for a correction under subsection (1) if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record. 2004, c. 3, Sched. A, s. 55 (8).

Exceptions

(9) Despite subsection (8), a health information custodian is not required to correct a record of personal health information if,

(a) it consists of a record that was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise and authority to correct the record; or

(b) it consists of a professional opinion or observation that a custodian has made in good faith about the individual. 2004, c. 3, Sched. A, s. 55 (9).

Duties upon correction

(10) Upon granting a request for a correction under subsection (1), the health information custodian shall,

(a) make the requested correction by,

(i) recording the correct information in the record and,

(A) striking out the incorrect information in a manner that does not obliterate the record, or

(B) if that is not possible, labeling the information as incorrect, severing the incorrect information from the record, storing it separately from the record and maintaining a link in the record that enables a person to trace the incorrect information, or

(ii) if it is not possible to record the correct information in the record, ensuring that there is a practical system in place to inform a person who accesses the record that the information in the record is incorrect and to direct the person to the correct information;

(b) give notice to the individual of what it has done under clause (a);

(c) at the request of the individual, give written notice of the requested correction, to the extent reasonably possible, to the persons to whom the custodian has disclosed the information with respect to which the individual requested the correction of the record, except if the correction cannot reasonably be expected to have an effect on the ongoing provision of health care or other benefits to the individual. 2004, c. 3, Sched. A, s. 55 (10).

Notice of refusal

(11) A notice of refusal under subsection (3) or (4) must give the reasons for the refusal and inform the individual that the individual is entitled to,

(a) prepare a concise statement of disagreement that sets out the correction that the health information custodian has refused to make;

(b) require that the health information custodian attach the statement of disagreement as part of the records that it holds of the individual's personal health information and disclose the statement of disagreement whenever the custodian discloses information to which the statement relates;

(c) require that the health information custodian make all reasonable efforts to disclose the statement of disagreement to any person who would have been notified under clause (10) (c) if the custodian had granted the requested correction; and

(d) make a complaint about the refusal to the Commissioner under Part VI. 2004, c. 3, Sched. A, s. 55 (11).

Rights of individual

(12) If a health information custodian, under subsection (3) or (4), refuses a request for a correction under subsection (1), in whole or in part, or is deemed to have refused the request, the individual is entitled to take the actions described in any of clauses (11) (a), (b), (c) and (d). 2004, c. 3, Sched. A, s. 55 (12).

Custodian's duty

(13) If the individual takes an action described in clause (11) (b) or (c), the health information custodian shall comply with the requirements described in the applicable clause. 2004, c. 3, Sched. A, s. 55 (13).

PART VI
ADMINISTRATION AND ENFORCEMENT

COMPLAINTS, REVIEWS AND INSPECTIONS

Complaint to Commissioner

56. (1) A person who has reasonable grounds to believe that another person has contravened or is about to contravene a provision of this Act or its regulations may make a complaint to the Commissioner. 2004, c. 3, Sched. A, s. 56 (1).

Time for complaint

(2) A complaint that a person makes under subsection (1) must be in writing and must be filed within,

(a) one year after the subject-matter of the complaint first came to the attention of the complainant or should reasonably have come to the attention of the complainant, whichever is the shorter; or

(b) whatever longer period of time that the Commissioner permits if the Commissioner is satisfied that it does not result in any prejudice to any person. 2004, c. 3, Sched. A, s. 56 (2).

Same, refusal of request

(3) A complaint that an individual makes under subsection 54 (8) or 55 (7) or (12) shall be in writing and shall be filed within six months from the time at which the health information custodian refuses or is deemed to have refused the individual's request mentioned in the applicable subsection. 2004, c. 3, Sched. A, s. 56 (3).

Non-application

(4) The *Ombudsman Act* does not apply to any matter in respect of which a complaint may be made to the Commissioner under this Act or to the Commissioner or his or her employees or delegates acting under this Act. 2004, c. 3, Sched. A, s. 56 (4).

Response of Commissioner

57. (1) Upon receiving a complaint made under this Act, the Commissioner may inform the person about whom the complaint is made of the nature of the complaint and,

(a) inquire as to what means, other than the complaint, that the complainant is using or has used to resolve the subject-matter of the complaint;

(b) require the complainant to try to effect a settlement, within the time period that the Commissioner specifies, with the person about which the complaint is made; or

(c) authorize a mediator to review the complaint and to try to effect a settlement, within the time period that the Commissioner specifies, between the complainant and the person about which the complaint is made. 2004, c. 3, Sched. A, s. 57 (1).

Dealings without prejudice

(2) If the Commissioner takes an action described in clause (1) (b) or (c) but no settlement is effected within the time period specified,

(a) none of the dealings between the parties to the attempted settlement shall prejudice the rights and duties of the parties under this Act;

(b) none of the information disclosed in the course of trying to effect a settlement shall prejudice the rights and duties of the parties under this Act; and

(c) none of the information disclosed in the course of trying to effect a settlement and that is subject to mediation privilege shall be used or disclosed outside the attempted settlement, including in a review of a complaint under this section or in an inspection under section 60, unless all parties expressly consent. 2004, c. 3, Sched. A, s. 57 (2).

Commissioner's review

(3) If the Commissioner does not take an action described in clause (1) (b) or (c) or if the Commissioner takes an action described in one of those clauses but no settlement is effected within the time period specified, the Commissioner may review the subject-matter of a complaint made under this Act if satisfied that there are reasonable grounds to do so. 2004, c. 3, Sched. A, s. 57 (3).

No review

(4) The Commissioner may decide not to review the subject-matter of the complaint for whatever reason the Commissioner considers proper, including if satisfied that,

(a) the person about which the complaint is made has responded adequately to the complaint;

(b) the complaint has been or could be more appropriately dealt with, initially or completely, by means of a procedure, other than a complaint under this Act;

(c) the length of time that has elapsed between the date when the subject-matter of the complaint arose and the date the complaint was made is such

that a review under this section would likely result in undue prejudice to any person;

(d) the complainant does not have a sufficient personal interest in the subject-matter of the complaint; or

(e) the complaint is frivolous or vexatious or is made in bad faith. 2004, c. 3, Sched. A, s. 57 (4).

Notice

(5) Upon deciding not to review the subject-matter of a complaint, the Commissioner shall give notice of the decision to the complainant and shall specify in the notice the reason for the decision. 2004, c. 3, Sched. A, s. 57 (5).

Same

(6) Upon deciding to review the subject-matter of a complaint, the Commissioner shall give notice of the decision to the person about whom the complaint is made. 2004, c. 3, Sched. A, s. 57 (6).

Commissioner's self-initiated review

58. (1) The Commissioner may, on his or her own initiative, conduct a review of any matter if the Commissioner has reasonable grounds to believe that a person has contravened or is about to contravene a provision of this Act or its regulations and that the subject-matter of the review relates to the contravention. 2004, c. 3, Sched. A, s. 58 (1).

Notice

(2) Upon deciding to conduct a review under this section, the Commissioner shall give notice of the decision to every person whose activities are being reviewed. 2004, c. 3, Sched. A, s. 58 (2).

Conduct of Commissioner's review

59. (1) In conducting a review under section 57 or 58, the Commissioner may make the rules of procedure that the Commissioner considers necessary and the *Statutory Powers Procedure Act* does not apply to the review. 2004, c. 3, Sched. A, s. 59 (1).

Evidence

(2) In conducting a review under section 57 or 58, the Commissioner may receive and accept any evidence and other information that the Commissioner sees fit, whether on oath or by affidavit or otherwise and whether or not it is or would be admissible in a court of law. 2004, c. 3, Sched. A, s. 59 (2).

Inspection powers

60. (1) In conducting a review under section 57 or 58, the Commissioner may, without a warrant or court order, enter and inspect any premises in accordance with this section if,

(a) the Commissioner has reasonable grounds to believe that,

(i) the person about whom the complaint was made or the person whose activities are being reviewed is using the premises for a purpose related to the subject-matter of the complaint or the review, as the case may be, and

(ii) the premises contains books, records or other documents relevant to the subject-matter of the complaint or the review, as the case may be;

(b) the Commissioner is conducting the inspection for the purpose of determining whether the person has contravened or is about to contravene a provision of this Act or its regulations; and

(c) the Commissioner does not have reasonable grounds to believe that a person has committed an offence. 2004, c. 3, Sched. A, s. 60 (1).

Review powers

(2) In conducting a review under section 57 or 58, the Commissioner may,

(a) demand the production of any books, records or other documents relevant to the subject-matter of the review or copies of extracts from the books, records or other documents;

(b) inquire into all information, records, information practices of a health information custodian and other matters that are relevant to the subject-matter of the review;

(c) demand the production for inspection of anything described in clause (b);

(d) use any data storage, processing or retrieval device or system belonging to the person being investigated in order to produce a record in readable form of any books, records or other documents relevant to the subject-matter of the review; or

(e) on the premises that the Commissioner has entered, review or copy any books, records or documents that a person produces to the Commissioner, if the Commissioner pays the reasonable cost recovery fee that the health information custodian or person being reviewed may charge. 2004, c. 3, Sched. A, s. 60 (2).

Entry to dwellings

(3) The Commissioner shall not, without the consent of the occupier, exercise a power to enter a place that is being used as a dwelling, except under the authority of a search warrant issued under subsection (4). 2004, c. 3, Sched. A, s. 60 (3).

Search warrants

(4) Where a justice of the peace is satisfied by evidence upon oath or affirmation that there is reasonable ground to believe it is necessary to enter a place that is being used as a dwelling to investigate a complaint that is the subject of a review under section 57, he or she may issue a warrant authorizing the entry by a person named in the warrant. 2004, c. 3, Sched. A, s. 60 (4).

Time and manner for entry

(5) The Commissioner shall exercise the power to enter premises under this section only during reasonable hours for the premises and only in such a manner so as not to interfere with health care that is being provided to any person on the premises at the time of entry. 2004, c. 3, Sched. A, s. 60 (5).

No obstruction

(6) No person shall obstruct the Commissioner who is exercising powers under this section or provide the Commissioner with false or misleading information. 2004, c. 3, Sched. A, s. 60 (6).

Written demand

(7) A demand for books, records or documents or copies of extracts from them under subsection (2) must be in writing and must include a statement of the nature of the things that are required to be produced. 2004, c. 3, Sched. A, s. 60 (7).

Obligation to assist

(8) If the Commissioner makes a demand for any thing under subsection (2), the person having custody of the thing shall produce it to the Commissioner and, at the request of the Commissioner, shall provide whatever assistance is reasonably necessary, including using any data storage, processing or retrieval device or system to produce a record in readable form, if the demand is for a document. 2004, c. 3, Sched. A, s. 60 (8).

Removal of documents

(9) If a person produces books, records and other documents to the Commissioner, other than those needed for the current health care of any person, the Commissioner may, on issuing a written receipt, remove them and may review or copy any of them if the Commissioner is not able to review and copy them on the premises that the Commissioner has entered. 2004, c. 3, Sched. A, s. 60 (9).

Return of documents

(10) The Commissioner shall carry out any reviewing or copying of documents with reasonable dispatch, and shall forthwith after the reviewing or copying return the documents to the person who produced them. 2004, c. 3, Sched. A, s. 60 (10).

Admissibility of copies

(11) A copy certified by the Commissioner as a copy is admissible in evidence to the same extent, and has the same evidentiary value, as the thing copied. 2004, c. 3, Sched. A, s. 60 (11).

Answers under oath

(12) In conducting a review under section 57 or 58, the Commissioner may, by summons, in the same manner and to the same extent as a superior court of record, require the appearance of any person before the Commissioner and compel them to give oral or written evidence on oath or affirmation. 2004, c. 3, Sched. A, s. 60 (12).

Inspection of record without consent

(13) Despite subsections (2) and (12), the Commissioner shall not inspect a record of, require evidence of, or inquire into, personal health information without the consent of the individual to whom it relates, unless,

(a) the Commissioner first determines that it is reasonably necessary to do so, subject to any conditions or restrictions that the Commissioner specifies, which shall include a time limitation, in order to carry out the review and that the public interest in carrying out the review justifies dispensing with obtaining the individual's consent in the circumstances; and

(b) the Commissioner provides a statement to the person who has custody or control of the record to be inspected, or the evidence or information to be inquired into, setting out the Commissioner's determination under clause (a) together with brief written reasons and any restrictions and conditions that the Commissioner has specified. 2004, c. 3, Sched. A, s. 60 (13).

Limitation on delegation

(14) Despite subsection 67 (1), the power to make a determination under clause (13) (a) and to approve the brief written reasons under clause (13) (b) may not be delegated except to the Assistant Commissioner. 2004, c. 3, Sched. A, s. 60 (14).

Document privileged

(15) A document or thing produced by a person in the course of an inquiry is privileged in the same manner as if the inquiry were a proceeding in a court. 2004, c. 3, Sched. A, s. 60 (15).

Protection

(16) Except on the trial of a person for perjury in respect of his or her sworn testimony, no statement made or answer given by that or any other person in the course of a review by the Commissioner is admissible in evidence in any court or at any inquiry or in any other proceedings, and no evidence in respect of proceedings before the Commissioner shall be given against any person. 2004, c. 3, Sched. A, s. 60 (16).

Protection under federal Act

(17) The Commissioner shall inform a person giving a statement or answer in the course of a review by the Commissioner of the person's right to object to answer any question under section 5 of the *Canada Evidence Act*. 2004, c. 3, Sched. A, s. 60 (17).

Representations

(18) The Commissioner shall give the person who made the complaint, the person about whom the complaint is made and any other affected person an opportunity to make representations to the Commissioner. 2004, c. 3, Sched. A, s. 60 (18).

Representative

(19) A person who is given an opportunity to make representations to the Commissioner may be represented by counsel or another person. 2004, c. 3, Sched. A, s. 60 (19).

Access to representations

(20) The Commissioner may permit a person to be present during the representations that another person makes to the Commissioner or to have access to them unless doing so would reveal,

(a) the substance of a record of personal health information, for which a health information custodian claims to be entitled to refuse a request for access made under section 53; or

(b) personal health information to which an individual is not entitled to request access under section 53. 2004, c. 3, Sched. A, s. 60 (20).

Proof of appointment

(21) If the Commissioner or Assistant Commissioner has delegated his or her powers under this section to an officer or employee of the Commissioner, the officer or employee who exercises the powers shall, upon request, produce the certificate of delegation signed by the Commissioner or Assistant Commissioner, as the case may be. 2004, c. 3, Sched. A, s. 60 (21).

Powers of Commissioner

61. (1) After conducting a review under section 57 or 58, the Commissioner may,

(a) if the review relates to a complaint into a request by an individual under subsection 53 (1) for access to a record of personal health information, make an order directing the health information custodian about whom the complaint was made to grant the individual access to the requested record;

(b) if the review relates to a complaint into a request by an individual under subsection 55 (1) for correction of a record of personal health information, make an order directing the health information custodian about whom a complaint was made to make the requested correction;

(c) make an order directing any person whose activities the Commissioner reviewed to perform a duty imposed by this Act or its regulations;

(d) make an order directing any person whose activities the Commissioner reviewed to cease collecting, using or disclosing personal health information if the Commissioner determines that the person is collecting, using or disclosing the information, as the case may be, or is about to do so in

contravention of this Act, its regulations or an agreement entered into under this Act;

(e) make an order directing any person whose activities the Commissioner reviewed to dispose of records of personal health information that the Commissioner determines the person collected, used or disclosed in contravention of this Act, its regulations or an agreement entered into under this Act but only if the disposal of the records is not reasonably expected to adversely affect the provision of health care to an individual;

(f) make an order directing any health information custodian whose activities the Commissioner reviewed to change, cease or not commence an information practice specified by the Commissioner, if the Commissioner determines that the information practice contravenes this Act or its regulations;

(g) make an order directing any health information custodian whose activities the Commissioner reviewed to implement an information practice specified by the Commissioner, if the Commissioner determines that the information practice is reasonably necessary in order to achieve compliance with this Act and its regulations;

(h) make an order directing any person who is an agent of a health information custodian, whose activities the Commissioner reviewed and that an order made under any of clauses (a) to (g) directs to take any action or to refrain from taking any action, to take the action or to refrain from taking the action if the Commissioner considers that it is necessary to make the order against the agent to ensure that the custodian will comply with the order made against the custodian; or

(i) make comments and recommendations on the privacy implications of any matter that is the subject of the review. 2004, c. 3, Sched. A, s. 61 (1).

Terms of order

(2) An order that the Commissioner makes under subsection (1) may contain the terms that the Commissioner considers appropriate. 2004, c. 3, Sched. A, s. 61 (2).

Copy of order, etc.

(3) Upon making comments, recommendations or an order under subsection (1), the Commissioner shall provide a copy of them, including reasons for any order made, to,

(a) the complainant and the person about whom the complaint was made, if the Commissioner made the comments, recommendations or order after conducting a review under section 57 of a complaint;

(b) the person whose activities the Commissioner reviewed, if the Commissioner made the comments, recommendations or order after conducting a review under section 58;

(c) all other persons to whom the order is directed;

(d) the body or bodies that are legally entitled to regulate or review the activities of a health information custodian directed in the order or to whom the comments or recommendations relate; and
(e) any other person whom the Commissioner considers appropriate. 2004, c. 3, Sched. A, s. 61 (3).

No order

(4) If, after conducting a review under section 57 or 58, the Commissioner does not make an order under subsection (1), the Commissioner shall give the complainant, if any, and the person whose activities the Commissioner reviewed a notice that sets out the Commissioner's reasons for not making an order. 2004, c. 3, Sched. A, s. 61 (4).

Appeal of order

62. (1) A person affected by an order of the Commissioner made under any of clauses 61 (1) (c) to (h) may appeal the order to the Divisional Court on a question of law in accordance with the rules of court by filing a notice of appeal within 30 days after receiving the copy of the order. 2004, c. 3, Sched. A, s. 62 (1).

Certificate of Commissioner

(2) In an appeal under this section, the Commissioner shall certify to the Divisional Court,
(a) the order and a statement of the Commissioner's reasons for making the order;
(b) the record of all hearings that the Commissioner has held in conducting the review on which the order is based;
(c) all written representations that the Commissioner received before making the order; and
(d) all other material that the Commissioner considers is relevant to the appeal. 2004, c. 3, Sched. A, s. 62 (2).

Confidentiality of information

(3) In an appeal under this section, the court may take precautions to avoid the disclosure by the court or any person of any personal health information about an individual, including, where appropriate, receiving representations without notice, conducting hearings in private or sealing the court files. 2004, c. 3, Sched. A, s. 62 (3).

Court order

(4) On hearing an appeal under this section, the court may, by order,
(a) direct the Commissioner to make the decisions and to do the acts that the Commissioner is authorized to do under this Act and that the court considers proper; and
(b) if necessary, vary or set aside the Commissioner's order. 2004, c. 3, Sched. A, s. 62 (4).

Compliance by Commissioner

(5) The Commissioner shall comply with the court's order. 2004, c. 3, Sched. A, s. 62 (5).

Enforcement of order

63. An order made by the Commissioner under this Act that has become final as a result of there being no further right of appeal may be filed with the Superior Court of Justice and on filing becomes and is enforceable as a judgment or order of the Superior Court of Justice to the same effect. 2004, c. 3, Sched. A, s. 63.

Further order of Commissioner

64. (1) After conducting a review under section 57 or 58 and making an order under subsection 61 (1), the Commissioner may rescind or vary the order or may make a further order under that subsection if new facts relating to the subject-matter of the review come to the Commissioner's attention or if there is a material change in the circumstances relating to the subject-matter of the review. 2004, c. 3, Sched. A, s. 64 (1).

Circumstances

(2) The Commissioner may exercise the powers described in subsection (1) even if the order that the Commissioner rescinds or varies has been filed with the Superior Court of Justice under section 63. 2004, c. 3, Sched. A, s. 64 (2).

Copy of order, etc.

(3) Upon making a further order under subsection (1), the Commissioner shall provide a copy of it to the persons described in clauses 61 (3) (a) to (e) and shall include with the copy a notice setting out,

(a) the Commissioner's reasons for making the order; and

(b) if the order was made under any of clauses 61 (1) (c) to (h), a statement that the persons affected by the order have the right to appeal described in subsection (4). 2004, c. 3, Sched. A, s. 64 (3).

Appeal

(4) A person affected by an order that the Commissioner rescinds, varies or makes under any of clauses 61 (1) (c) to (h) may appeal the order to the Divisional Court on a question of law in accordance with the rules of court by filing a notice of appeal within 30 days after receiving the copy of the order and subsections 62 (2) to (5) apply to the appeal. 2004, c. 3, Sched. A, s. 64 (4).

Damages for breach of privacy

65. (1) If the Commissioner has made an order under this Act that has become final as the result of there being no further right of appeal, a person affected by the order may commence a proceeding in the Superior Court of Justice for damages for actual harm that the person has suffered as a result of a contravention of this Act or its regulations. 2004, c. 3, Sched. A, s. 65 (1).

Same

(2) If a person has been convicted of an offence under this Act and the conviction has become final as a result of there being no further right of appeal, a person affected by the conduct that gave rise to the offence may commence a proceeding in the Superior Court of Justice for damages for actual harm that the person has suffered as a result of the conduct. 2004, c. 3, Sched. A, s. 65 (2).

Damages for mental anguish

(3) If, in a proceeding described in subsection (1) or (2), the Superior Court of Justice determines that the harm suffered by the plaintiff was caused by a contravention or offence, as the case may be, that the defendants engaged in wilfully or recklessly, the court may include in its award of damages an award, not exceeding $10,000, for mental anguish. 2004, c. 3, Sched. A, s. 65 (3).

COMMISSIONER

General powers

66. The Commissioner may,

(a) engage in or commission research into matters affecting the carrying out of the purposes of this Act;

(b) conduct public education programs and provide information concerning this Act and the Commissioner's role and activities;

(c) receive representations from the public concerning the operation of this Act;

(d) on the request of a health information custodian, offer comments on the custodian's actual or proposed information practices;

(e) assist in investigations and similar procedures conducted by a person who performs similar functions to the Commissioner under the laws of Canada, except that in providing assistance, the Commissioner shall not use or disclose information collected by or for the Commissioner under this Act;

(f) in appropriate circumstances, authorize the collection of personal health information about an individual in a manner other than directly from the individual. 2004, c. 3, Sched. A, s. 66.

Delegation

67. (1) The Commissioner may in writing delegate any of the Commissioner's powers, duties or functions under this Act, including the power to make orders, to the Assistant Commissioner or to an officer or employee of the Commissioner. 2004, c. 3, Sched. A, s. 67 (1).

Subdelegation by Assistant Commissioner

(2) The Assistant Commissioner may in writing delegate any of the powers, duties or functions delegated to him or her under subsection (1) to any other officers or employees of the Commissioner, subject to the conditions and

restrictions that the Assistant Commissioner specifies in the delegation. 2004, c. 3, Sched. A, s. 67 (2).

Limitations re personal health information

68. (1) The Commissioner and any person acting under his or her authority may collect, use or retain personal health information in the course of carrying out any functions under this Part solely if no other information will serve the purpose of the collection, use or retention of the personal health information and in no other circumstances. 2004, c. 3, Sched. A, s. 68 (1).

Extent of information

(2) The Commissioner and any person acting under his or her authority shall not in the course of carrying out any functions under this Part collect, use or retain more personal health information than is reasonably necessary to enable the Commissioner to perform his or her functions relating to the administration of this Act or for a proceeding under it. 2004, c. 3, Sched. A, s. 68 (2).

Confidentiality

(3) The Commissioner, the Assistant Commissioner and persons acting on behalf of or under the direction of either of them shall not disclose any information that comes to their knowledge in the course of exercising their functions under this Act unless,

(a) the disclosure is required for the purpose of exercising those functions;

(b) the information relates to a health information custodian, the disclosure is made to a body that is legally entitled to regulate or review the activities of the custodian and the Commissioner or the Assistant Commissioner is of the opinion that the disclosure is justified;

(c) the Commissioner obtained the information under subsection 60 (12) and the disclosure is required in a prosecution for an offence under section 131 of the *Criminal Code* (Canada) in respect of sworn testimony; or

(d) the disclosure is made to the Attorney General, the information relates to the commission of an offence against an Act or an Act of Canada and the Commissioner is of the view that there is evidence of such an offence. 2004, c. 3, Sched. A, s. 68 (3).

Same

(4) Despite anything in subsection (3), the Commissioner, the Assistant Commissioner and persons acting on behalf of or under the direction of either of them shall not disclose,

(a) any quality of care information that comes to their knowledge in the course of exercising their functions under this Act; or

(b) the identity of a person, other than a complainant under subsection 56 (1), who has provided information to the Commissioner and who has requested the Commissioner to keep the person's identity confidential. 2004, c. 3, Sched. A, s. 68 (4).

Information in review or proceeding

(5) The Commissioner in a review under section 57 or 58 and a court, tribunal or other person, including the Commissioner, in a proceeding mentioned in section 65 or this section shall take every reasonable precaution, including, when appropriate, receiving representations without notice and conducting hearings that are closed to the public, to avoid the disclosure of any information for which a health information custodian is entitled to refuse a request for access made under section 53. 2004, c. 3, Sched. A, s. 68 (5).

Not compellable witness

(6) The Commissioner, the Assistant Commissioner and persons acting on behalf of or under the direction of either of them shall not be required to give evidence in a court or in a proceeding of a judicial nature concerning anything coming to their knowledge in the exercise of their functions under this Act that they are prohibited from disclosing under subsection (3) or (4). 2004, c. 3, Sched. A, s. 68 (6).

Immunity

69. No action or other proceeding for damages may be instituted against the Commissioner, the Assistant Commissioner or any person acting on behalf of or under the direction of either of them for,

(a) anything done, reported or said in good faith and in the exercise or intended exercise of any of their powers or duties under this Act; or

(b) any alleged neglect or default in the exercise in good faith of any of their powers or duties under this Act. 2004, c. 3, Sched. A, s. 69.

PART VII
GENERAL

Non-retaliation

70. No one shall dismiss, suspend, demote, discipline, harass or otherwise disadvantage a person by reason that,

(a) the person, acting in good faith and on the basis of reasonable belief, has disclosed to the Commissioner that any other person has contravened or is about to contravene a provision of this Act or its regulations;

(b) the person, acting in good faith and on the basis of reasonable belief, has done or stated an intention of doing anything that is required to be done in order to avoid having any person contravene a provision of this Act or its regulations;

(c) the person, acting in good faith and on the basis of reasonable belief, has refused to do or stated an intention of refusing to do anything that is in contravention of a provision of this Act or its regulations; or

(d) any person believes that the person will do anything described in clause (a), (b) or (c). 2004, c. 3, Sched. A, s. 70.

Immunity

71. (1) No action or other proceeding for damages may be instituted against a health information custodian or any other person for,

(a) anything done, reported or said, both in good faith and reasonably in the circumstances, in the exercise or intended exercise of any of their powers or duties under this Act; or

(b) any alleged neglect or default that was reasonable in the circumstances in the exercise in good faith of any of their powers or duties under this Act. 2004, c. 3, Sched. A, s. 71 (1).

Crown liability

(2) Despite subsections 5 (2) and (4) of the *Proceedings Against the Crown Act*, subsection (1) does not relieve the Crown of liability in respect of a tort committed by a person mentioned in subsection (1) to which it would otherwise be subject. 2004, c. 3, Sched. A, s. 71 (2).

Substitute decision-maker

(3) A person who, on behalf of or in the place of an individual, gives or refuses consent to a collection, use or disclosure of personal health information about the individual, makes a request, gives an instruction or takes a step is not liable for damages for doing so if the person acts reasonably in the circumstances, in good faith and in accordance with this Act and its regulations. 2004, c. 3, Sched. A, s. 71 (3).

Reliance on assertion

(4) Unless it is not reasonable to do so in the circumstances, a person is entitled to rely on the accuracy of an assertion made by another person, in connection with a collection, use or disclosure of, or access to, the information under this Act, to the effect that the other person,

(a) is a person who is authorized to request access to a record of personal health information under section 53;

(b) is a person who is entitled under section 5 or 23 or subsection 26 (1) to consent to the collection, use or disclosure of personal health information about another individual;

(c) meets the requirement of clauses 26 (2) (b) and (c); or

(d) holds the beliefs described in subsection 26 (5). 2004, c. 3, Sched. A, s. 71 (4).

Offences

72. (1) A person is guilty of an offence if the person,

(a) wilfully collects, uses or discloses personal health information in contravention of this Act or its regulations;

(b) makes a request under this Act, under false pretences, for access to or correction of a record of personal health information;

(c) in connection with the collection, use or disclosure of personal health information or access to a record of personal health information, makes an assertion, knowing that it is untrue, to the effect that the person,

(i) is a person who is entitled to consent to the collection, use or disclosure of personal health information about another individual,

(ii) meets the requirement of clauses 26 (2) (b) and (c),

(iii) holds the beliefs described in subsection 26 (5), or

(iv) is a person entitled to access to a record of personal health information under section 52;

(d) disposes of a record of personal health information in the custody or under the control of the custodian with an intent to evade a request for access to the record that the custodian has received under subsection 53 (1);

(e) wilfully disposes of a record of personal health information in contravention of section 13;

(f) contravenes subsection 34 (2), (3) or (4) or clause 47 (15) (a), (e) or (f);

(g) wilfully obstructs the Commissioner or a person known to be acting under the authority of the Commissioner in the performance of his or her functions under this Act;

(h) wilfully makes a false statement to mislead or attempt to mislead the Commissioner or a person known to be acting under the authority of the Commissioner in the performance of his or her functions under this Act;

(i) wilfully fails to comply with an order made by the Commissioner or a person known to be acting under the authority of the Commissioner under this Act; or

(j) contravenes section 70. 2004, c. 3, Sched. A, s. 72 (1).

Penalty

(2) A person who is guilty of an offence under subsection (1) is liable, on conviction,

(a) if the person is a natural person, to a fine of not more than $50,000; and

(b) if the person is not a natural person, to a fine of not more than $250,000. 2004, c. 3, Sched. A, s. 72 (2).

Officers, etc.

(3) If a corporation commits an offence under this Act, every officer, member, employee or other agent of the corporation who authorized the offence, or who had the authority to prevent the offence from being committed but knowingly refrained from doing so, is a party to and guilty of the offence and is liable, on conviction, to the penalty for the offence, whether or not the corporation has been prosecuted or convicted. 2004, c. 3, Sched. A, s. 72 (3).

No prosecution

(4) No person is liable to prosecution for an offence against this or any other Act by reason of complying with a requirement of the Commissioner under this Act. 2004, c. 3, Sched. A, s. 72 (4).

Commencing a prosecution

(5) No person other than the Attorney General or a counsel or agent acting on behalf of the Attorney General may commence a prosecution for an offence under subsection (1). 2004, c. 3, Sched. A, s. 72 (5).

Regulations

73. (1) Subject to section 74, the Lieutenant Governor in Council may make regulations,

(a) prescribing or specifying anything that this Act describes as being prescribed, specified, described, provided for, authorized or required in the regulations made under this Act;

(b) exempting persons or classes of persons from the persons described in clause (d) of the definition of "health care practitioner" in section 2;

(c) specifying persons or classes of persons who shall not be included in the definition of "health information custodian" in subsection 3 (1);

(d) specifying that certain types of information shall or shall not be included in the definition of "personal health information" in subsection 4 (1);

(e) defining, for the purposes of this Act and its regulations, any word or expression used in this Act that has not already been expressly defined in this Act;

(f) making any provision of this Act or its regulations, that applies to some but not all health information custodians, applicable to a prescribed person mentioned in paragraph 8 of the definition of "health information custodian" in subsection 3 (1) or a member of a prescribed class of persons mentioned in that paragraph;

(g) specifying requirements with respect to information practices for the purposes of subsection 10 (1), including conditions that a health information custodian is required to comply with when collecting, using or disclosing personal health information or classes of personal health information, or specifying procedural processes or requirements for setting requirements with respect to information practices for the purposes of that subsection;

(h) specifying requirements, or a process for setting requirements, for the purposes of subsection 10 (3) with which a health information custodian is required to comply when using electronic means to collect, use, modify, disclose, retain or dispose of personal health information, including standards for transactions, data elements for transactions, code sets for data elements and procedures for the transmission and authentication of electronic signatures;

(i) specifying requirements for the purposes of subsection 17 (1), including requiring that a health information custodian and its agent enter into an

agreement that complies with the regulations made under clause (k) before the custodian provides personal health information to the agent;

(j) specifying requirements that an agreement entered into under this Act or its regulations must contain;

(k) specifying requirements, restrictions or prohibitions with respect to the collection, use or disclosure of any class of personal health information by any person in addition to the requirements, restrictions or prohibitions set out in this Act;

(l) specifying requirements that an express instruction mentioned in clause 37 (1) (a), 38 (1) (a) or 50 (1) (e) must meet;

(m) permitting notices, statements or any other things, that under this Act are required to be provided in writing, to be provided in electronic or other form instead, subject to the conditions or restrictions that are specified by the regulations made under this Act;

(n) prescribing under what circumstances the Canadian Blood Services may collect, use and disclose personal health information, the conditions that apply to the collection, use and disclosure of personal health information by the Canadian Blood Services and disclosures that may be made by a health information custodian to the Canadian Blood Services;

(o) specifying information relating to the administration or enforcement of this Act that is required to be contained in a report made under subsection 58 (1) of the *Freedom of Information and Protection of Privacy Act*;

(p) respecting any matter necessary or advisable to carry out effectively the purposes of this Act. 2004, c. 3, Sched. A, s. 73 (1).

General or specific application

(2) A regulation made under this Act may be of general application or specific to any person or persons or class or classes in its application. 2004, c. 3, Sched. A, s. 73 (2).

Classes

(3) A class described in the regulations made under this Act may be described according to any characteristic or combination of characteristics and may be described to include or exclude any specified member, whether or not with the same characteristics. 2004, c. 3, Sched. A, s. 73 (3).

Public consultation before making regulations

74. (1) Subject to subsection (7), the Lieutenant Governor in Council shall not make any regulation under section 73 unless,

(a) the Minister has published a notice of the proposed regulation in *The Ontario Gazette* and given notice of the proposed regulation by all other means that the Minister considers appropriate for the purpose of providing notice to the persons who may be affected by the proposed regulation;

(b) the notice complies with the requirements of this section;

(c) the time periods specified in the notice, during which members of the public may exercise a right described in clause (2) (b) or (c), have expired; and

(d) the Minister has considered whatever comments and submissions that members of the public have made on the proposed regulation in accordance with clause (2) (b) or (c) and has reported to the Lieutenant Governor in Council on what, if any, changes to the proposed regulation the Minister considers appropriate. 2004, c. 3, Sched. A, s. 74 (1).

Contents of notice

(2) The notice mentioned in clause (1) (a) shall contain,

(a) a description of the proposed regulation and the text of it;

(b) a statement of the time period during which members of the public may submit written comments on the proposed regulation to the Minister and the manner in which and the address to which the comments must be submitted;

(c) a description of whatever other rights, in addition to the right described in clause (b), that members of the public have to make submissions on the proposed regulation and the manner in which and the time period during which those rights must be exercised;

(d) a statement of where and when members of the public may review written information about the proposed regulation;

(e) all prescribed information; and

(f) all other information that the Minister considers appropriate. 2004, c. 3, Sched. A, s. 74 (2).

Time period for comments

(3) The time period mentioned in clauses (2) (b) and (c) shall be at least 60 days after the Minister gives the notice mentioned in clause (1) (a) unless the Minister shortens the time period in accordance with subsection (4). 2004, c. 3, Sched. A, s. 74 (3).

Shorter time period for comments

(4) The Minister may shorten the time period if, in the Minister's opinion,

(a) the urgency of the situation requires it;

(b) the proposed regulation clarifies the intent or operation of this Act or the regulations; or

(c) the proposed regulation is of a minor or technical nature. 2004, c. 3, Sched. A, s. 74 (4).

Discretion to make regulations

(5) Upon receiving the Minister's report mentioned in clause (1) (d), the Lieutenant Governor in Council, without further notice under subsection (1), may make the proposed regulation with the changes that the Lieutenant Governor in Council considers appropriate, whether or not those changes are mentioned in the Minister's report. 2004, c. 3, Sched. A, s. 74 (5).

No public consultation

(6) The Minister may decide that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 73 if, in the Minister's opinion,

(a) the urgency of the situation requires it;

(b) the proposed regulation clarifies the intent or operation of this Act or the regulations; or

(c) the proposed regulation is of a minor or technical nature. 2004, c. 3, Sched. A, s. 74 (6).

Same

(7) If the Minister decides that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 73,

(a) those subsections do not apply to the power of the Lieutenant Governor in Council to make the regulation; and

(b) the Minister shall give notice of the decision to the public and to the Commissioner as soon as is reasonably possible after making the decision. 2004, c. 3, Sched. A, s. 74 (7).

Contents of notice

(8) The notice mentioned in clause (7) (b) shall include a statement of the Minister's reasons for making the decision and all other information that the Minister considers appropriate. 2004, c. 3, Sched. A, s. 74 (8).

Publication of notice

(9) The Minister shall publish the notice mentioned in clause (7) (b) in *The Ontario Gazette* and give the notice by all other means that the Minister considers appropriate. 2004, c. 3, Sched. A, s. 74 (9).

Temporary regulation

(10) If the Minister decides that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 73 because the Minister is of the opinion that the urgency of the situation requires it, the regulation shall,

(a) be identified as a temporary regulation in the text of the regulation; and

(b) unless it is revoked before its expiry, expire at a time specified in the regulation, which shall not be after the second anniversary of the day on which the regulation comes into force. 2004, c. 3, Sched. A, s. 74 (10).

No review

(11) Subject to subsection (12), neither a court, nor the Commissioner shall review any action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the Minister under this section. 2004, c. 3, Sched. A, s. 74 (11).

Exception

(12) Any person resident in Ontario may make an application for judicial review under the *Judicial Review Procedure Act* on the grounds that the Minister has not taken a step required by this section. 2004, c. 3, Sched. A, s. 74 (12).

Time for application

(13) No person shall make an application under subsection (12) with respect to a regulation later than 21 days after the day on which,

(a) the Minister publishes a notice with respect to the regulation under clause (1) (a) or subsection (9), where applicable; or

(b) the regulation is filed, if it is a regulation described in subsection (10). 2004, c. 3, Sched. A, s. 74 (13).

Review of Act

75. A committee of the Legislative Assembly shall,

(a) begin a comprehensive review of this Act not later than the third anniversary of the day on which this section comes into force; and

(b) within one year after beginning that review, make recommendations to the Assembly concerning amendments to this Act. 2004, c. 3, Sched. A, s. 75.

76.-98. OMITTED (AMENDS OR REPEALS OTHER ACTS). 2004, c. 3, Sched. A, ss. 76-98.

99. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS ACT). 2004, c. 3, Sched. A, s. 99.

100. OMITTED (ENACTS SHORT TITLE OF THIS ACT). 2004, c. 3, Sched. A, s. 100.

Policies and Guidelines

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Policies and Guidelines:
Clinical Practice

Policy

Type:	Quality Assurance Program		
Name:	Continuing Education: January 1, 2021 – December 31, 2023		
Status:	Approved	**Version:**	1
Date Approved:	December 4, 2020	**Date Revised:**	

Purpose

The purpose of this policy is to outline the requirements of continuing education that must be met by optometrists in the three-year continuing education cycle: January 1, 2021 to December 31, 2023.

Participation in Continuing Education

As per the *Optometry Act,* 1991. O. Reg. 119/94, a key component of the College's Quality Assurance Program is mandatory Continuing Education (CE). Optometrists are required to participate in the CE component to ensure their continuing competence and quality improvement, to address changes in practice environments, and to ensure they remain current with changes in technology, scope and standards of practice.

Current Cycle

The current cycle runs from January 1, 2021 to December 31, 2023.

Optometrists must complete a minimum of **seventy (70)** credit hours of continuing education related to the maintenance of their standards of practice or continuing competence by the end of the three-year cycle.

Breakdown

Of those 70 hours, an optometrist must complete:

- **a minimum of 50 (fifty)** hours of Council on Optometric Practitioner Education (COPE) accredited CE;
    - **20 (twenty)** of those COPE accredited hours must be in topics reasonably related to ocular disease and management or related systemic disease;
    - an optometrist may claim **30 COPE-equivalent hours** during the cycle a Fellowship or Diplomate in the American Academy of Optometry (FAAO) or Fellowship in the College of Optometrists in Vision Development (FCOVD) is awarded; and
- **the remaining 20 (twenty)** hours may be obtained by completing COPE accredited CE or other learning opportunities, which give optometrists a wider range of options and the opportunity to make flexible selections that suit their learning needs and practice.

Accepted learning opportunities for the remaining 20 hours include:

Learning Opportunities	Calculation of CE Credit Hours
Organized events: conferences, education, events, and lectures that are not COPE-accredited	Hour-for-hour
Professional journals: reading of articles in refereed optometric, ophthalmologic, or medical journal	Hour-for-hour
Distance learning activities: print, internet, video that are not COPE accredited	Hour-for-hour
Graduate studies in optometry or a related health discipline preapproved by the Quality Assurance Panel	Full-time studies (5 days/week): 20 hours per year Part-time studies (less than 5 days/week): 10 hours per year
Residency at an ACOE-accredited school	20 hours per cycle
Faculty/staff optometrist appointment at an ACOE-accredited school	Full-time (5 days/week): 20 hours per year Part-time (less than 5 days/week): 10 hours per year
Publication of an article in a refereed optometric, ophthalmologic, or medical journal	10 hours
Publication of a case report in a refereed journal	2 hours
Lectures prepared and given to regulated health professionals for their primary continuing education or regulated health professionals in training education at a Canadian or American accredited school. If a faculty member prepares and gives lectures to regulated health professionals as part of their appointment, they may claim CE credit hours either for their faculty appointment or lectures prepared and given to regulated health professionals, but not both.	3 credit hours/hour of lecture—each lecture may be counted one time only
Supervising optometrist for students from ACOE-accredited schools (including external clerkship) or the IOBP	Full-time (5 days/week): 1 hour per week Part-time (less than 5 days/week): 0.5 hour per week

Participation in an organization approved to administer an entry-to-practice examination or an evaluating examination for foreign-trained practitioners.	**Clinical Assessor**: 1 credit hour per two hours spent assessing or training to assess candidates **Question Author**: 1 credit hour per question accepted to the database **Question Item Selector**: 1 credit hour per two hours spent selecting questions for the examinations
Certification in a Cardiopulmonary Resuscitation (CPR) Heart Saver AED (C) or CPR HCP (Health Care Provider) level with AED	5 hours per cycle

New Registrants

Optometrists may only claim CE credit hours that have been completed following their initial registration with the College. Newly registered optometrists during the current cycle will be required to complete a prorated number of hours based on their registration year as follows:

Year of Registration	Total Hours	COPE Accredited Hours (*)	Other Learning Opportunities Hours
2021	47	34 (14)	13
2022	24	17 (7)	7
2023	No requirement	No requirement	No requirement

*Number of COPE accredited hours that must be in topics reasonably related to ocular disease and management or related systemic disease

Participation Verification Certificate

A participation verification certificate must be issued for COPE accredited CE activities.

For other learning opportunities, optometrists must complete the 'Continuing Education: Other Learning Opportunities' form, which requires the following information:

- **Activity**: select one of the accepted learning opportunities;
- **Instructor**: name of the instructor of the CE activity or "Self" if there is no instructor;
- **Provider/resource used**: name of the provider of the CE activity or the resource material used;
- **Format**: select one of the activity formats. There are two options for online formats:
    - **Online – Interactive**: webinar, video conference, teleconference, or other format that allows for immediate interaction and feedback between the audience and the instructor. Once the event has taken place, optometrists may no longer participate in that activity; and
    - **Online – Enduring**: webcast, podcast, video, journal, website, written or other format that provides one-way content to the audience without immediate interaction with the

instructor. There is not just one time on one day to participate in the activity, rather, the optometrists determine when they participate;

- **Presentation (if applicable):** select one of the activity presentations or leave blank if not applicable;
- **Category:** select one of the activity categories. See "COPE Categories" for description of each category;
- **Date:** date of completion of the activity;
- **City, Province/State, Country**: location of the activity; and
- **Number of credit hours claimed**: number of credit hours claimed for the activity.

CE Exclusions

Although the College recognizes the value in trade show participation, this activity does not qualify for CE.

Reporting of Hours

Optometrists must **self-declare completion** of CE requirements on their **Annual Report** at the end of the three-year cycle (2023).

Optometrists must **also submit all CE credit hours to OE TRACKER**. It is the responsibility of the optometrist to claim only credit hours that is relevant to their maintenance of practice and/or continuing competence. Some CE providers send COPE accredited attendance information directly to OE TRACKER. Otherwise, the optometrist must submit their own certificates for COPE accredited CE activities. For other learning opportunities, optometrists must submit completed 'Continuing Education: Other Learning Opportunities' forms to OE TRACKER. The College will verify optometrists' reporting hours through individual OE TRACKER profiles. It is incumbent upon optometrists to ensure that their OE TRACKER profiles are up to date, particularly toward the end of the CE cycle.

Deficiency Audit

The College will perform a deficiency audit at the conclusion of this three-year reporting cycle. The deficiency audit identifies those who fail to meet the CE hour requirement.

As per the *Optometry Act,* the Registrar is required to refer optometrists who fail to acquire the required number of CE credit hours to the Quality Assurance Committee for a practice assessment. As such, optometrists found to be deficient in CE hours based on the breakdown above will be required to participate in a practice assessment at their own cost according to the College's Schedule of Fees and Penalties.

Digital Imaging/Fundus Photography in Optometric Practice

***Bulletin*, Spring 2008**

The College is aware that some members have established a policy of using digital imaging and/or fundus photography for all patients as the only method of examining the fundus. Currently, there is no peer-reviewed, scientific evidence that shows digital imaging to be effective for all patients as a stand-alone technique for examination of the fundus. Accordingly, the College does not support such a policy.

The College believes that there is no single technique currently available that can be used exclusively for the examination of the fundus of all patients. The College acknowledges that in some subsequent examinations, retinal digital imaging /photography alone may be sufficient. In other cases, digital imaging or photography will reveal the need for further examination using one or more additional techniques, including binocular examination through a dilated pupil. In these cases, use of digital imaging/photography alone may lead the optometrist to miss certain pathologies. Accordingly, the College believes that digital imaging/photography should be used in conjunction with other current techniques, including pupil dilation.

With regard to record keeping, the College expects members to record their analysis of a digital image or photograph in the patient's record. This may be accomplished using a note-taking feature of a digital imaging system if it is so equipped. Simply acknowledging that the picture was taken is not considered an analysis of the fundus.

Optometric Prescriptions: Re-examination of Patients

***Bulletin*, Dec. 2002**

A patient may come to your office with a prescription for spectacles issued by a fellow optometrist, an ophthalmologist or another medical practitioner. If you observe an apparent anomaly or obscurity in the prescription or if, after dispensing, the patient returns to you intolerant of the eyeglasses, you should report the matter to the prescribing practitioner and seek to agree upon an appropriate course of action. You should not re-examine the patient and issue a new prescription unless the original prescriber has clearly expressed support for such action, or the patient independently requests an opinion from you about the matter.

To act otherwise is not only discourteous but a breach of professional conduct in its implication that the original prescriber has made an error which it is the

optometrist's business to rectify. If, as is always possible, an error has occurred, it can be put right inoffensively by discussion with the original prescriber.

Optometric Prescriptions: Refusing a Prescription

***Bulletin*, Nov. 1989**

Occasionally the College receives a complaint wherein an optometrist has refused to fill a prescription written by another practitioner. Upon presentation of a prescription written by another practitioner, the complainant was allegedly told that they would have to undergo a second eye examination in order for the optometrist to provide the complainant with spectacles.

Members are cautioned that conduct such as that outlined above could lead to allegations of professional misconduct.

Optometric Prescriptions: Release of Prescriptions

2014

A Regulation under the *Optometry Act* (O. Reg. 119/94) clearly states that a member of the College must provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses. The *Health Insurance Act* makes the provision of a written refractive prescription one of the non-discretionary components of a periodic oculo-visual assessment.

What if it's been 18 months since I examined the patient?
You will note that the Regulation does not make the length of time from examination a variable in the issuance of a prescription. If it is your professional judgment that the prescription has a low probability of still being valid, you are advised to make this known to the patient at the time of their request. You should record your advice to the patient. However, you cannot make the final decision of whether to have the prescription updated for the patient. If they choose to go against your advice, it is their privilege to do so. Write the prescription and sign it. The date should reflect the day upon which the pertinent examination took place, not the date of release.

Can I charge for this service?
The original prescription is part of the examination fee. Any replacement copies can be charged to the patient at a reasonable fee.

Opticians call me all the time asking for a prescription. Can I give it to them without having the patient signing a release form?

Opticians, like optometrists, are regulated health professionals. Under O. Reg.119/94 Part IV, Section 11 (5) you may, for the purposes of providing health care, give a health professional any information from your record.

The provision of a prescription is one such transmission of information. You can give the information to the optician over the telephone, by fax or any other medium that is convenient to you and the optician. The patient is not required to sign a release for this sharing of information.

Removal of Corneal Foreign Bodies

***Bulletin*, Feb. 1994**

Superficial corneal foreign bodies are a common problem. The *Regulated Health Professions Act, 1991* (RHPA) and the *Optometry Act,* bring the removal of corneal foreign bodies into question since the profession does not have the controlled act nor an exemption to the controlled act of "performing a procedure in or below the surface of the cornea."

The result of this present statutory status is that members may continue to remove a foreign body lodged **on** the surface of the cornea but not **in** the cornea since the former procedure (clinical situation) is not a controlled act and continues to be an integral part of the practice of optometry. Accordingly, professional judgment must be exercised in differentiating those foreign bodies that are embedded below the surface of the cornea and below the level of Bowman's membrane.

The removal of a foreign body lodged on the surface of the cornea should continue to be done in accordance with expected standards of practice which includes the taking of a history and particulars of the incident, the appropriate clinical investigation and making of a drawing or recording of the position of the foreign body, development of a management plan and advice for prophylactic care, and follow-up assessment as required, or referral to an appropriate registered health care professional.

It has been noted by the Ministry of Health that Section 29(1)(a) under the RHPA provides an exemption to S.27(1), the “controlled acts”, if a procedure “is done in the course of rendering first aid or is of temporary assistance in an emergency.”

The College agrees that this exemption would protect the member from the legal ramifications of the RHPA. However, the situation being what it is, the College would caution members that in the event of an untoward incident arising from this

"first aid" or "temporary assistance" the member may find him/herself civilly liable and may not be covered by professional liability insurance. Therefore, members should check with their insurance carriers.

Spectacle Therapy using the Internet

Professional and Regulatory Standards Interpreted

Introduction

This document describes how optometrists may utilize their website and/or the internet in spectacle dispensing practices, while meeting the standards of practice of the profession. Ophthalmic dispensing is defined as “the preparation, adaptation and delivery” of vision correction, and is a controlled act in Ontario authorized to optometrists, physicians and opticians:

> 3. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

Standard of Practice for Spectacle Therapy

Section 6.4 Spectacle Therapy in the Optometric Practice Reference (OPR) describes the professional standards for spectacle therapy. Optometrists providing spectacle therapy must satisfy the following standards, regardless of whether or not technology is used as a tool to facilitate the provision of spectacle therapy to patients,

- Reviewing with the patient any relevant environmental, occupational, avocational, and/or physical factors affecting spectacle wear;
- Reviewing the details of the prescription;
- Advising the patient regarding appropriate ophthalmic materials;
- **T**aking appropriate measurements (including but not limited to interpupillary distance and segment height) to ensure proper function of the spectacles;
- Arranging for the fabrication of the spectacles;
- Verifying the accuracy of the completed spectacles to ensure that they meet required tolerances;
- Fitting or adjusting the spectacles to the patient;
- Counselling the patient on aspects of spectacle wear including, but not limited to: the use, expectations, limitations, customary adaptation period and maintenance requirements of the spectacles.

Application of the Standard when providing Spectacle Therapy using the Internet

Reviewing factors affecting spectacle wear: Optometrists must review, with patients, factors affecting spectacle wear. This can be done either in-person, or by telephone, video conference, or online questionnaire. If this review is not performed in-person, optometrists should include a precaution for patients that in-person reviews are recommended for individuals with special needs or atypical facial and/or postural features. If optometrists choose specific patient factors by which to limit their internet dispensing services, including, but not limited to, a specific age range, this should be disclosed on the website where patients can easily find it.

Reviewing the details of the prescription: Optometrists must review prescription details. This can be done in-person or using the internet. Optometrists are responsible for confirming the validity and/or veracity of prescriptions and must have a mechanism in place to do so. Prescriptions provided using the internet must be provided in a secure manner and collected in an unaltered form (pdf/image). All prescriptions must contain information that clearly identifies the prescriber (including name, address, telephone number and signature), and specifies the identity of the patient and the date prescribed (OPR 5.2 The Prescription). All prescriptions must include an expiry date.

Advising the patient regarding appropriate ophthalmic materials: Optometrists must advise patients regarding appropriate ophthalmic materials. This may be done in-person or by an online algorithm. In the latter scenario, patients must be given clear directions on how to contact the office/optometrist with any questions they may have.

Taking appropriate measurements: Optometrists must take appropriate measurements when providing spectacle therapy. These can be done in-person or by computer application. If computer applications are used (in-office or remotely) to determine dispensing measurements, optometrists must be satisfied that the application determines these measurements with equal accuracy to traditional in-person measurements, including the production of supportable evidence should this matter come to the attention of the College.

Arranging for the fabrication of the spectacles: Optometrists must review the suitability of patient orders before arranging for the fabrication of spectacles.

Verifying the accuracy of the completed spectacles: Optometrists must verify the accuracy of completed spectacles.

Fitting or adjusting the spectacles to the patient: Fitting or adjusting the spectacles to patients must be performed in-office and cannot be performed virtually, by tutorial and/or video conferencing. Optometrists providing spectacle therapy will possess the equipment required to fit and adjust spectacles. In-person fitting and adjusting of spectacles provides a final verification and mitigates risk of harm by confirming that patients leave the clinic with spectacles

that have been properly verified, fit and adjusted. In-person delivery of spectacles establishes a patient/practitioner relationship in circumstances where patients are new to the clinic and spectacle therapy was initiated through the optometrist's website.

Counseling the patient regarding spectacle wear: Counseling regarding spectacle wear is ongoing and involves in-office, telephone, and/or electronic communications.

Additional Considerations

Delegation: Optometrists who delegate elements of spectacle dispensing (for example, the fitting and adjusting of spectacles) to staff who are not authorized to independently perform the controlled act, must be present in the same physical location as their patient and able to intervene, unless another optometrist is present to provide appropriate delegation (OPR 4.3 Delegation and Assignment).

Most Responsible Dispenser: In collaborative or multi-optometrist practices, where multiple optometrists may participate in dispensing spectacles to an individual patient, the College considers that the last optometrist to provide care, or "touch the patient", typically the optometrist fitting or adjusting the spectacles, is the most responsible dispenser. This optometrist is responsible for all preceding steps in the dispensing process, as well as the performance of the spectacles and any potential risk of harm to the patient. Similarly, where optometrists practice in working arrangements with opticians, the most responsible dispenser is the last professional to provide care to the patient.

Jurisdiction: Ontario-based optometrists providing care to patients in other jurisdictions (provinces/states) may need to be registered in those jurisdictions and should consult with the appropriate regulatory authorities. Optometrists participating in any aspect of ophthalmic dispensing in Ontario must be registered with the College of Optometrists of Ontario.

The Patient Record: Internet prescriptions and orders must be maintained in the patient record (OPR 5.1 The Patient Record).

Internet Sites: Where the internet is used in the provision of spectacle therapy, websites must:

- comply with College advertising guidelines and relevant paragraphs in the Professional Misconduct regulation (O. Reg. 119/94, Part I under the Optometry Act);

- identify the website as belonging to or referring to a member registered with the College of Optometrists of Ontario;

- collect and record patient information in a private and secure manner respecting patient confidentiality;
- identify the physical location of the clinic/dispensary, including address and city/town, and the hours of operation of the clinic; and
- include the telephone number to contact the clinic/dispensary.

Telehealth Policy for Optometrists

(September 2017)

Introduction

Telehealth refers to the practice of optometry at a spatial and/or temporal distance by exchanging health information via electronic communications. Telehealth activities include the provision of optometric services as well as the administration and sharing of health information and digital records.

Principles

Optometrists engaged in telehealth:

- Must meet the standards of practice;[1]
- Have the same ethical duties and obligations as when providing care to patients in person;
- Will use their judgment when deciding whether telehealth is appropriate for patients; and
- Will communicate and collaborate effectively with patients, optometrists, and other health-care providers while protecting patient privacy.

Standards of Practice for Telehealth

Optometrists must obtain informed consent for the use of telehealth and the same standards of practice[1,2] that protect patients during in-person interactions apply equally when care is delivered electronically.

Optometrists must comply with privacy regulations[3] and ensure that:

- Where patient information is stored on mobile devices or offsite in an identifiable form, the information is encrypted;

[1] The Optometric Practice Reference (OPR) articulates the standards of practice for optometrists in Ontario: http://www.collegeoptom.on.ca/images/pdfs/030_iD_COO_OPR_book_WEB.pdf

[2] Spectacle Therapy Using the Internet describes how optometrists may utilize their website and/or the internet in spectacle dispensing practices: http://www.collegeoptom.on.ca/members/professional-practice/policy/366-spectacle-therapy-using-the-internet-2015/

[3] Privacy regulations are constantly evolving and optometrists may want to contact the Office of the Information and Privacy Commissioner of Ontario for updated advice and information: https://www.ipc.on.ca/?redirect=https://www.ipc.on.ca/

- Optometrist-initiated electronic communications are appropriately protected (e.g., encrypted); and
- All information is maintained collectively in patient health records.

Optometrists must ensure that any measuring apparatuses or remote applications used during telehealth are reliable. Results obtained and their interpretation must be equivalent to those obtained when practising in person.

Establishing a Patient–Practitioner Relationship
Optometrists should not provide advice and/or care to patients using telehealth until a patient–practitioner relationship has been established.
A patient–practitioner relationship is not required when optometrists provide consultation services for other optometrists or regulated health professionals using telecommunication.

Interjurisdictional Considerations
Optometrists must be registered, practise within the scope of practice, and maintain appropriate professional liability insurance in the jurisdiction where patients are located.

Therapeutic Pharmaceutical Agents (TPA) Certification

Therapeutic Pharmaceutical Agents (TPA) certification allows optometrists to prescribe drugs to their patients. The deadline for members of the College to become certified in TPAs has been extended to January 1, 2017. Following this date, members who were not deemed to be TPA-certified by the College previously will not be able to become TPA-certified. However, they can practise without prescribing therapeutic pharmaceutical drugs.

In addition, starting on January 1, 2017, new applicants for registration must be TPA-certified prior to making their applications to the College. This includes those applying for registration in Ontario under labour mobility provisions. Applicants currently in the system would be accepted under the current system. Applicants presently in the system would be accepted under the current requirements.

It is becoming increasingly difficult to find 100- and 20-hour TPA courses; however, the College of Optometry at Nova Southeastern University has committed to offering a 100-hour TPA course from June 9–18, 2016.

The Designated Drugs Regulation details the drugs that TPA-certified optometrists can prescribe.

Members are encouraged to carefully review the TPA Education Policy to determine where their own education and qualifications fit in and to determine what, if any, upgrading or continuing education program they may need to complete.

Criteria for 100- and 20-hour TPA Courses

The Educational Requirements for Members to Prescribe Drugs policy refers to a 100-hour course and a 20-hour refresher course. Council has approved the following criteria for these courses.

100-hour Course:

- Course content must be developed by an Accreditation Council on Optometric Education (ACOE)-accredited school. (The ACOE requirement will ensure the quality of the course content but a non-ACOE provider may work with the ACOE school re: providing a venue and putting on the course.)
- The content must have a minimum of 60 hours didactic and a minimum of 40 hours clinical instruction.
- Participants must pass the course exam.

20-hour Refresher Course:

- The course must be a single, cohesive course that refreshes and updates members' knowledge regarding the categories of therapeutic pharmaceutical agents that would usually be used for the treatment and management of ocular disease. (A 20-hr refresher course that is too narrow in scope [focused particularly on one condition or area of practice] does not meet this criterion. GE courses taken over the last five years are unlikely to meet this criterion unless they were designed specifically as a 20-hour, comprehensive TPA refresher course.)
- The course content must be developed by an ACOE-accredited school.

Policies and Guidelines:
Administrative/Practice Management

Access to Applicant Information and Records Policy

Effective Date: July 17, 2014

Overview

Applicants for pre-registration and registration are entitled to access documents provided to the College of Optometrists (College) as part of their application process. Authorized individuals including College staff, are also able to access applicant information and records.

Who may access records

Applicants for pre-registration and registration may access documents or records provided to the College as part of their application process. Only authorized staff involved in the pre-registration and/or registration processes, and any persons or organizations that may in any way be relevant to the applicant's application for registration with the College, may access information from applicant records.

How an applicant can ask for records

Applicants for pre-registration and registration can simply submit a written request to College registration staff to access documents provided to the College as part of their application process**.**

The way in which records are made available

Applicants can obtain the documents provided to the College as part of their application process as long as a request was made in writing by the applicant at least five (5) days prior.

How long the records are kept

Applicant records related to registration applications are kept for 24 months (or two years) which is the period that registration applications are valid for. Three months prior to the expiry of the registration application period, a letter is written by the College to notify the applicant that the application expiry period is imminent and that the applicant's records will be returned to the applicant if the applicant does not notify the College of his/her intention to continue with the registration application.

Applicant records related to pre-registration applications are kept for the period of time that prior learning assessment (PLA) exam results are valid for. Currently, PLA exam results are valid for a period of three (3) years following an applicant's first PLA exam attempt. Since the College is conducting credential assessment on an interim basis, this would also depend on whether or not the transition to the national credential assessment process takes place prior to the expiry of the PLA exam results validity period.

What limitations (if any) exist on right to access the records

No limitations exist on the right to access the records as long as the records are still with the College. However, the College will refuse to provide an applicant with any information that in the College's opinion jeopardizes the safety of any person.

Examples of documents accessible by applicants

An applicant is entitled to access the following types of documents if they are available in the applicant's file:

Pre-registration

Item	Document Description
1	Pre-registration Form
2	English proficiency test results
3	World Education Services authentication report
4	Course descriptions/syllabi
5	Degree certificates/transcripts

Registration

Item	Document Description
1	Registration Application Form
2	Degree certificates/transcripts

3	Canadian Standard Assessment in Optometry (CSAO)/Canadian Assessment of Competence in Optometry (CACO) exam results
4	Canadian citizenship/permanent residency or authorization under the *Immigration Act* to engage in the practice of optometry document
5	Certificate of Standing (if applicable)
6	Ontario Optometric Jurisprudence Exam results
7	Criminal Record Check

Advertising

Introduction

The following guidelines describe how optometrists may represent themselves and their qualifications in their advertising, practice names and general business practices. 'Advertisement' is defined as including any message expressed in any language and communicated in any medium to anyone in circumstances which could influence the recipient's choice, opinion or behaviour. Generally, informational advertising, if it is truthful and understandable, serves the public interest. Persuasive advertising is professionally divisive and ethically objectionable, and may lead vulnerable members of society to personally or financially invest in health services, products or ventures that are not of benefit to them. These guidelines have been created to delineate between informational and persuasive advertising.

Relevant Professional Misconduct Regulations (O.Reg. 119/94 Part I)

Representations of Members and their Qualifications

19. Using a term, title or designation in respect of the member's practice other than "optometrist" or "doctor of optometry".

20. Using, in the course of providing or offering to provide professional services, any reference to the member's education or educational achievement other than the member's university degree, unless the use of the reference is approved by Council.

21. Identifying oneself to a patient as a person who is qualified to practise as a member of a health profession other than optometry, unless lawfully entitled to

do so in Ontario under the legislation governing that profession.

Advertising

22. Publishing or using, or knowingly permitting the publication or use of an advertisement, announcement or information that promotes or relates to the provision of professional services by a member to the public, whether in a document, business card, business sign, website, or any other format which,

i. is false or deceptive, whether by reason of inclusion of or omission of information,

ii. suggests that the member is a specialist or is specially educated, trained or qualified other than where the reference is to an educational achievement and the reference has been approved by Council,

iii. contains a testimonial or comparative or superlative statements,

iv. contains an endorsement other than an endorsement by an individual or organization that has demonstrated, to the satisfaction of Council, that the individual or organization has expertise relevant to the subject matter of the endorsement,

v. is not factual, objectively verifiable or readily comprehensible to the persons to whom it is directed, or

vi. would be reasonably regarded by members as demeaning the integrity or dignity of the profession or likely to bring the profession into disrepute.

Guidelines

Representation of Members and their Qualifications:

Members may only refer to themselves using the terms “optometrist” or “doctor of optometry”. No other designation, or descriptor is allowed in practice name or advertising. In all practice communications members should represent themselves as optometrists and not as physicians. Optometrists should not say anything themselves or allow anything to be said on their behalf in advertising or elsewhere that would lead people to believe they are physicians.

Members are allowed to use any earned university degrees, however, it must be made clear to patients that they are optometrists. Members may only refer to fellowships or other educational achievements that have been approved by

Council. To date, the only fellowship or educational achievement that has been approved for use by Council is fellowship in the American Academy of Optometry.

Members may only hold themselves out as being members of another profession if they are registered to practice that profession in Ontario through the relevant health regulatory college.

Advertising

Advertising regulations now include practice name, as well as any advertising by a member in any medium. As well as requirements that advertising not mislead the public, there continue to be prohibitions on the use of testimonials, superlatives and comparatives (e.g. "*At Any Town Optometric Clinic you'll get a better examination and prescription than at any other clinic in town*" would be prohibited.) Since the regulation includes practice names, members cannot use practice names with superlatives (eg. "*Best Eyecare Centre*" would not be allowed). There are currently no specialist designations that are approved by the College for use by members, therefore members cannot call themselves a specialist in any area of practice.

Endorsements may be allowed if Council is satisfied that the individual or organization has the expertise relevant to the subject matter of the endorsement.

Conflict of Interest and Independent Contractors

Sharing fees can give rise to (the perception of) conflict of interest. Optometrists are prohibited from sharing fees with anyone except another optometrist or physician, engaged in the practice of medicine.

Members who practise as independent contractors must have a written agreement that ensures, among other provisions, that any advertising relating to the professional services provided by the member meets the requirements set out in regulations made under the Act. Members are responsible for any advertising of their practice, even if it is paid for by another entity. Optometrists must not advertise fee sharing promotions with 'deal-of-the-day' websites (e.g. Groupon, LivingSocial), or opticians or corporations with whom they practice as independent contractors.

In Office Material vs. Advertising

Promotional materials for use within the office only are not considered advertising, and as such are not subject to these guidelines. However, web sites are accessible by the general public and are therefore considered to be advertising and are subject to these regulations.

As always, the College's foremost concern is to safeguard the interest of the public. These guidelines will allow for greater flexibility in the choice members have in advertising their practices while maintaining tasteful and appropriate public exposure for the profession.

Anti-Discrimination Policy Guidelines

The College's Code of Ethics

The College's By-laws include a Code of Ethics. The Code of Ethics reaffirms the duty of an optometrist to treat all patients with respect, not to discriminate against patients, and to make efforts to provide individuals in need with optometric care.

Optometrists should keep in mind their ethical obligations under the Code of Ethics in all of their patient care decisions.

Purpose of the Policy Guidelines

The purpose of the Policy Guidelines is to assist optometrists in understanding their legal and ethical obligations to provide services to the public without discrimination on prohibited grounds.

Overview

Patients are entitled to access optometry and other health care services in a way that respects their human rights. Optometrists must comply with the Ontario Human Rights Code (the "Human Rights Code")[4] when making decisions on accepting patients, providing care, and ending the optometrist-patient relationship.

Optometrists are not obligated to provide or continue to provide optometric services if the reason is not prohibited by the Human Rights Code. However, optometrists must ensure that patients and potential patients are always treated with dignity and respect, and that services are only discontinued in accordance with the College's regulations and policies.

Requirements of the Human Rights Code

The Human Rights Code requires optometrists to treat all patients and potential patients equally, regardless of the patient's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability. It is discriminatory to refuse to accept, treat, or continue to treat a patient for any of these reasons.

Requirement to Provide Reasonable Accommodation

The *Human Rights Code* requires optometrists to accommodate the needs of patients and potential patients with disabilities, as well as any needs of patients relating to family

[4] R.S.O. 1990, c. H. 19

status and other grounds set out in the *Human Rights Code*. Accommodations must be made to the point of "undue hardship". The term "undue hardship" is not defined in the *Human Rights Code*. However, in determining whether an accommodation would cause undue hardship, the *Human Rights Code* requires individuals to consider cost, outside sources of funding, if any, and health and safety requirements.[5] This means that optometrists are expected to accommodate patients' needs at their own expense, and to incur some hardship in doing so.

How to Provide Accommodations and Accessible Services – Concept of Undue Hardship

The Ontario Human Rights Commission's *Policy and guidelines on disability and the duty to accommodate* provide guidance on how optometrists can meet the duty to accommodate and what undue hardship means, as follows:

> "The Human Rights Code prescribes three considerations in assessing whether an accommodation would cause undue hardship. These are:
>
> - cost
> - outside sources of funding, if any
> - health and safety requirements, if any.
>
> The Supreme Court of Canada has said that, "one must be wary of putting too low a value on accommodating the disabled. It is all too easy to cite increased cost as a reason for refusing to accord the disabled equal treatment". The cost standard is therefore a high one.
>
> Costs will amount to undue hardship if they are:
>
> - quantifiable;
> - shown to be related to the accommodation; and
> - so substantial that they would alter the essential nature of the enterprise, or so significant that they would substantially affect its viability."

For more information on "undue hardship", please visit:

http://www.ohrc.on.ca/en/policy-and-guidelines-disability-and-duty-accommodate/5-undue-hardship

Optometrists should also keep in mind the requirements of the Accessibility Standards for Customer Service[6], a regulation to the *Accessibility for Ontarians with Disabilities Act*[7]. These requirements are explained in the College's publication regarding the Accessibility Standards.

[5] See subsections 11(2) and 17(2) of the *Human Rights Code*.

[6] O. Reg. 429/07

[7] *Accessibility for Ontarians with Disabilities Act, 2005*, S.O. 2005, c. 11

What the Human Rights Code Does Not Require

The Human Rights Code does not prevent optometrists from making clinical decisions or from accepting or refusing to continue to treat a patient on non-prohibited grounds. For example, the Human Rights Code does not require the optometrist to provide uninsured service free of charge. If an optometrist does not feel competent to treat a person, the Human Rights Code does not require the optometrist to do so.

Assessing an Applicant's Good Character

Approved by Council, September 30, 2015

Purpose

This policy explains, in the interests of transparency and fairness, how the College of Optometrists of Ontario assesses information from or about applicants for whom evidence of past conduct raises questions about their ability to practise optometry with honesty and integrity, which is also known as "good character."

Scope

This policy applies to all applicants who apply for a certificate of registration from the College of Optometrists of Ontario (the "College").

Background

The College's overriding mandate is to serve and protect the public interest. As part of its commitment to doing so, the College adopted a mission statement which provides:

> **Mission:** To serve the public by regulating Ontario's optometrists. The College uses its authority to guide the profession in the delivery of safe, ethical, progressive and quality eye care at the highest standards.

One of the ways in which the College ensures that the profession delivers safe and ethical eye care is by requiring applicants to be of good character. Good character can be understood as being willing and able to practise optometry with honesty, integrity and in accordance with the law.

While the College does not currently have an *explicit* general good character requirement in the Registration Regulation, good character is *implicitly* required by the College's Registration Regulation and the *Regulated Health Professions Act, 1991*. In addition, several other specific registration requirements help ensure that future members of the College are of good character, including:

- The requirement to have no previous findings of guilt in relation to a criminal offence;

- The requirement to have no previous findings or current proceedings regarding allegations of professional misconduct, incompetence or incapacity;
- The requirement not to make any false or misleading statements or representations in his or her application;
- The requirement for applicants who are already registered as optometrists in another Canadian jurisdiction to submit a certificate of good standing.

Applicants are generally presumed to be of good character unless and until evidence demonstrates otherwise. Good character remains an ongoing expectation of registered optometrists who are required to submit declarations about their conduct to the College as part of the annual registration renewal process.

The relevant legislation is set out in the attached Appendix 1.

Policy
Optometrists are expected to demonstrate honesty and integrity in all of their actions, to practise in an ethical and safe manner, and to comply with all legislation, regulations, College By-laws, and policy governing the profession.

Examples of conduct or circumstances that may give rise to doubt on the part of the Registrar that the applicant is of good character include, but are not limited to:

- A previous finding of professional misconduct, incompetence or incapacity by a regulatory body;
- A current proceeding regarding professional misconduct, incompetence or incapacity;
- A previous finding of guilt in relation to a criminal offence (including offences under the *Criminal Code*, the *Controlled Drugs and Substances Act* and the *Food and Drugs Act*);
- A previous or current charge in relation to a criminal offence;
- A previous finding or current proceeding in relation to discipline by a post-secondary education institution;
- A refusal by another optometric regulatory body to register the applicant;
- Other serious concerns that come to the attention of the College.

If the Registrar has doubts about whether an applicant is of good character, or is of the opinion that terms, conditions or limitations should be imposed, or proposes to refuse registration, the Registrar will refer the application to the Registration Committee in accordance with the *Regulated Health Professions Act, 1991*. The applicant will be provided with notice of the referral and an opportunity to make written submissions to the Registration Committee about his or her good character.

The Registration Committee of the College then reviews the application and the submissions, if any, in order to determine if the issuance of a certificate of registration—with or without terms, conditions and limitations—is in the public interest.

Referrals to the Registration Committee

Procedural Fairness

When making decisions about the issuance of a certificate of registration, the College is committed to ensuring that:

1. Decisions are made in the public interest.
2. Decisions are made using a process that is transparent and fair, by committee members acting in an objective and impartial manner.
3. Decisions are grounded in reasons that are fully explained in writing (unless the decision is to register the applicant with no terms, conditions or limitations in which case reasons are not required).
4. Decisions are made on the specific merits of the case under review.

Committee Role and Options

The Registration Committee reviews applications referred to it by the Registrar. The Registration Committee will review the application and any submissions of the applicant in order to make a determination of whether the applicant is of good character at the time of the application.

Supporting Documentation Submitted by the Applicant

When the Registrar has doubts about an applicant's character, the applicant has the onus of establishing that he or she is of good character. In other words, it is up to the applicant to prove to the College, generally through supporting documents, that the applicant is of good character.

Therefore, if an applicant answers "yes" to any declaration question on the application form, the College recommends that the applicant provide additional supporting documentation as follows:

- A personal statement describing the circumstances of the incident(s).
- In relation to any criminal charges or findings, official copies of any court transcripts, court information, reports, orders, reasons for decision, sentencing documents, probation orders or pardons.
- In relation to any regulatory findings, copies of any orders and reasons for decision.
- In relation to any outstanding regulatory proceedings, copies of any Notices of Hearing and interim orders.
- An explanation as to why the incident(s) is not relevant to the applicant's suitability to practise optometry (for example, is there evidence that rehabilitation and/or remediation was successful?)

- Evidence of compliance with any Order imposed by a court or another regulatory body.
- Letters of reference from employers or colleagues, including current ones, who are aware of the facts of the matter.

Applicants are responsible for making arrangements at their own expense with the proper authorities to have official information (such as transcripts) sent directly to the College.

The Registrar may request any of the above information if the Registrar has doubts about the applicant's good character.

The College keeps all information confidential except as required or allowed by law.

Factors to be Considered by the Registration Committee
In each case, several factors will be considered by the Registration Committee *vis à vis* the conduct under review, including the following:

1. The nature of the conduct, including:
    a. The seriousness and impact of the incident(s);
    b. The duration, repetition, concealment and apparent motivation of the incident(s);
    c. How long ago the incident(s) occurred;
    d. The relevance of the incident(s) to professional practice.

2. The honesty and completeness of the submission by the applicant:
    a. Has the applicant made an honest declaration on the application form? Or
    b. Did the College learn of an issue on receipt of a Certificate of Standing from another jurisdiction, from a criminal record check or other source?

3. The consequential actions of the applicant, such as:
    a. The outcome of any remediation or rehabilitation undertaken.
    b. The acceptance of responsibility, expression of remorse or provision of restitution by the applicant.
    c. The subsequent conduct of the applicant including any work, volunteer activities or practice of optometry with no further evidence of conduct issues arising.
    d. The development of measures or safeguards to prevent any repetition of the incident(s), such as establishing policies and procedures and developing monitoring and accountability mechanisms where appropriate.

Registration Committee Decisions
After considering the application, the submissions of the applicant and the factors set out above, a panel of the Registration Committee may:

- Direct the Registrar to register the applicant;
- Direct the Registrar to register the applicant with terms, conditions and limitations; or
- Direct the Registrar to refuse to register the applicant.

Where the Registration Committee determines that the public interest may be protected by directing the Registrar to register the applicant with terms, conditions and limitations, the following is a non-exhaustive list of the types of terms, conditions and limitations that may be imposed:

- practice supervision or monitoring;
- counselling or therapy;
- course work (e.g. ethics or boundaries course).

Decisions of the Registration Committee may be appealed by the applicant to the Health Professions Review and Appeal Board (HPARB) within 30 days of receipt of the written Decision and Reasons.

APPENDIX 1

Excerpts of Relevant Legislation

REGISTRATION REGULATION (O. Reg. 837/93) under the *Optometry Act, 1991, S.O. 1991, c. 35*, as amended

GENERAL CERTIFICATES OF REGISTRATION

2. (1) The requirements and qualifications for the issuing of a general certificate of registration to an applicant are:

[…]

4. Where the applicant has previously practised optometry, there must not be any finding of, or of any current proceeding involving an allegation of, professional misconduct, incompetence or incapacity or any like finding or proceeding against the applicant.

5. The applicant must not have been found guilty in relation to a criminal offence in any jurisdiction. For the purposes of this paragraph, a "criminal offence" includes, without being limited to, an offence under the *Criminal Code* (Canada), the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada).

[…]

(2) An applicant shall be deemed not to have satisfied the requirements for a certificate of registration if the applicant made a false or misleading statement or representation in his or her application. O. Reg. 837/93, s. 2 (2).

[…]

2.1 (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant for a general certificate of registration, the applicant is deemed to have met the requirements of paragraphs 2 and 7 of subsection 2 (1) of this Regulation. O. Reg. 279/12, s. 2.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as an optometrist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 279/12, s. 2.

(3) Without in any way limiting the generality of subsection (2), "good standing" shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding;

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as an optometrist.

[…]

3. It is a condition of a general certificate of registration that the member shall provide the College with details of either of the following that relate to the member and that occur or arise after the member is registered:

1. Where the member is or has been registered or licensed to practise optometry in another jurisdiction, a finding of professional misconduct, incompetence or incapacity or any like finding against the member.

2. A finding of guilt in relation to an offence in any jurisdiction. O. Reg. 224/03, s. 2; O. Reg. 279/12, s. 3.

[…]

ACADEMIC CERTIFICATES OF REGISTRATION

5. (1) The requirements and qualifications for issuing an academic certificate of registration are:

[…]

5. Where the applicant has previously been registered or licensed as an optometrist in any jurisdiction, or has previously practised optometry, there must not be any finding of, or current proceeding involving an allegation of, professional misconduct, incompetence, incapacity or any like finding or proceeding against the applicant.

6. The applicant must not have been found guilty in relation to a criminal offence in any jurisdiction. For the purposes of this paragraph, a "criminal offence" includes, without being limited to, an offence under the *Criminal Code* (Canada), the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada).

[…]

(2) An applicant shall be deemed not to have satisfied the requirements for a certificate of registration if the applicant made a false or misleading statement or representation in his or her application. O. Reg. 837/93, s. 5 (2).

5.1 (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant for an academic certificate of registration, the applicant is deemed to have met the requirements of paragraph 3 of subsection 5 (1) of this Regulation. O. Reg. 279/12, s. 7.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as an optometrist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 279/12, s. 7.

(3) Without in any way limiting the generality of subsection (2), "good standing" shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding;

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as an optometrist.

[…]

6. An academic certificate of registration is subject to the following terms, conditions and limitations:

[…]

3. The member must provide the College with details of either of the following that relate to the member and that occur or arise after the member is registered:

i. where the member is or has previously been registered or licensed as an optometrist in another jurisdiction, a finding of professional misconduct, incompetence, incapacity or any like finding or proceeding against the member, or

ii. a finding of guilt in relation to an offence in any jurisdiction. O. Reg. 224/03, s. 4; O. Reg. 279/12, s. 8.

[…]

9. (1) All qualifications or requirements for the issuing of a general certificate of registration are non-exemptible, other than requirements listed in paragraph 3, 4 or 5 of subsection 2 (1). O. Reg. 224/03, s. 4.

(2) All qualifications or requirements for the issuing of an academic certificate of registration are non-exemptible, other than requirements listed in paragraph 4, 5 or 6 of subsection 5 (1). O. Reg. 224/03, s. 4.

[…]

Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18

REGISTRATION

Registration

15. (1) If a person applies to the Registrar for registration, the Registrar shall,

(a) register the applicant; or

(b) refer the application to the Registration Committee. 1991, c. 18, Sched. 2, s. 15 (1).

Referrals to Registration Committee

(2) The Registrar shall refer an application for registration to the Registration Committee if the Registrar,

(a) has doubts, on reasonable grounds, about whether the applicant fulfils the registration requirements;

(a.1) is of the opinion that terms, conditions or limitations should be imposed on a certificate of registration of the applicant and the applicant is an individual described in subsection 22.18 (1);

(b) is of the opinion that terms, conditions or limitations should be imposed on a certificate of registration of the applicant and the applicant does not consent to the imposition; or

(c) proposes to refuse the application. 1991, c. 18, Sched. 2, s. 15 (2); 1993, c. 37, s. 6; 2009, c. 24, s. 33 (3).

Notice to applicant

(3) If the Registrar refers an application to the Registration Committee, he or she shall give the applicant notice of the statutory grounds for the referral and of the applicant's right to make written submissions under subsection 18 (1). 1991, c. 18, Sched. 2, s. 15 (3).

Terms, etc., attached on consent

(4) If the Registrar is of the opinion that a certificate of registration should be issued to an applicant with terms, conditions or limitations imposed and the applicant consents to the imposition, the Registrar may do so with the approval of a panel of the Registration Committee selected by the chair for the purpose. 1991, c. 18, Sched. 2, s. 15 (4).

Panels for consent

(5) Subsections 17 (2) and (3) apply with respect to the panel mentioned in subsection (4). 1991, c. 18, Sched. 2, s. 15 (5).

Disclosure of application file

16. (1) The Registrar shall give an applicant for registration, at his or her request, all the information and a copy of each document the College has that is relevant to the application.

Exception

(2) The Registrar may refuse to give an applicant anything that may, in the Registrar's opinion, jeopardize the safety of any person. 1991, c. 18, Sched. 2, s. 16.

Panels

17. (1) An application for registration referred to the Registration Committee or an application referred back to the Registration Committee by the Board shall be considered by a panel selected by the chair from among the members of the Committee. 1991, c. 18, Sched. 2, s. 17 (1); 2007, c. 10, Sched. M, s. 24 (1).

Composition of panels

(2) A panel shall be composed of at least three persons, at least one of whom shall be a person appointed to the Council by the Lieutenant Governor in Council. 2007, c. 10, Sched. M, s. 24 (2).

Quorum

(3) Three members of a panel constitute a quorum. 1991, c. 18, Sched. 2, s. 17 (3).

Consideration by panel

18. (1) An applicant may make written submissions to the panel within thirty days after receiving notice under subsection 15 (3) or within any longer period the Registrar may specify in the notice.

Orders by panel

(2) After considering the application and the submissions, the panel may make an order doing any one or more of the following:

1. Directing the Registrar to issue a certificate of registration.

2. Directing the Registrar to issue a certificate of registration if the applicant successfully completes examinations set or approved by the panel.

3. Directing the Registrar to issue a certificate of registration if the applicant successfully completes additional training specified by the panel.

4. Directing the Registrar to impose specified terms, conditions and limitations on a certificate of registration of the applicant and specifying a limitation on the applicant's right to apply under subsection 19 (1).

5. Directing the Registrar to refuse to issue a certificate of registration.

Idem

(3) A panel, in making an order under subsection (2), may direct the Registrar to issue a certificate of registration to an applicant who does not meet a registration requirement unless the requirement is prescribed as a non-exemptible requirement.

Order on consent

(4) The panel may, with the consent of the applicant, direct the Registrar to issue a certificate of registration with the terms, conditions and limitations specified by the panel imposed. 1991, c. 18, Sched. 2, s. 18.

Application for variation

19. (1) A member may apply to the Registration Committee for an order directing the Registrar to remove or modify any term, condition or limitation imposed on the member's certificate of registration as a result of a registration proceeding. 1991, c. 18, Sched. 2, s. 19 (1).

Limitations

(2) The right to apply under subsection (1) is subject to any limitation in the order imposing the term, condition or limitation or to which the member consented and to any limitation made under subsection (7) in the disposition of a previous application under this section. 1991, c. 18, Sched. 2, s. 19 (2).

Panels

(3) An application to the Registration Committee under subsection (1) or an application referred back to the Registration Committee by the Board shall be considered

by a panel selected by the chair from among the members of the Committee. 1991, c. 18, Sched. 2, s. 19 (3); 2007, c. 10, Sched. M, s. 25 (1).

Idem

(4) Subsections 17 (2) and (3) apply with respect to the panel mentioned in subsection (3). 1991, c. 18, Sched. 2, s. 19 (4).

Submissions

(5) An applicant may make written submissions to the panel. 1991, c. 18, Sched. 2, s. 19 (5).

Orders

(6) After considering the application and the submissions, the panel may make an order doing any one or more of the following:

1. Refusing the application.

2. Directing the Registrar to remove any term, condition or limitation imposed on the certificate of registration.

3. Directing the Registrar to modify terms, conditions or limitations on the certificate of registration. 1991, c. 18, Sched. 2, s. 19 (6); 2007, c. 10, Sched. M, s. 25 (2).

Limitations on applications

(7) When an application has been disposed of under this section, the applicant may not make a new application under subsection (1) within six months of the disposition without leave of the Registrar. 2007, c. 10, Sched. M, s. 25 (3).

Registrar's leave

(8) The Registrar may only give leave for a new application to be made under subsection (7) if the Registrar is satisfied that there has been a material change in circumstances that justifies the giving of the leave. 2007, c. 10, Sched. M, s. 25 (3).

Notice of orders

20. (1) A panel shall give the applicant notice of an order it makes under subsection 18 (2) or 19 (6) and written reasons for it if the order,

(a) directs the Registrar to refuse to issue a certificate of registration;

(b) directs the Registrar to issue a certificate of registration if the applicant successfully completes examinations or additional training;

(c) directs the Registrar to impose terms, conditions and limitations on a certificate of registration of the applicant; or

(d) refuses an application for an order removing or modifying any term, condition or limitation imposed on a certificate of registration. 1991, c. 18, Sched. 2, s. 20 (1).

Contents of notice

(2) A notice under subsection (1) shall inform the applicant of the order and of the provisions of section 19 and of subsections 21 (1) and (2). 1991, c. 18, Sched. 2, s. 20 (2); 2007, c. 10, Sched. M, s. 26.

Appeal to Board

21. (1) An applicant who has been given a notice under subsection 20 (1) of an order may require the Board to hold a review of the application and the documentary evidence in support of it, or a hearing of the application, by giving the Board and the Registration Committee notice in accordance with subsection (2).

Requirements of notice

(2) A notice under subsection (1) shall be a written notice, given within thirty days after the notice under subsection 20 (1) was given, specifying whether a review or a hearing is required.

Order, etc., to Board

(3) If the Registration Committee receives a notice that an applicant requires a hearing or review, it shall, within fifteen days after receiving the notice, give the Board a copy of the order made with respect to the application, the reasons for it and the documents and things upon which the decision to make the order was based.

When order may be carried out

(4) An order of a panel, notice of which is required under subsection 20 (1), may be carried out only when,

(a) the applicant has given the Registrar notice that the applicant will not be requiring a review or hearing;

(b) thirty-five days have passed since the notice of the order was given under subsection 20 (1) without the applicant requiring a review or hearing; or

(c) the Board has confirmed the order. 1991, c. 18, Sched. 2, s. 21.

Registration hearings or reviews

22. (1) This section applies to a hearing or review by the Board required by an applicant under subsection 21 (1). 1991, c. 18, Sched. 2, s. 22 (1).

Procedural provisions

(2) The following provisions apply with necessary modifications to a hearing or review:

1. Subsection 38 (4) (exclusion from panel).
2. Section 42 (disclosure of evidence).
3. Section 43 (no communication by panel members).
4. Section 50 (members of panel who participate).
5. Section 55 (release of evidence). 1991, c. 18, Sched. 2, s. 22 (2).

Idem

(3) The following provisions also apply with necessary modifications to a hearing:

1. Section 45 (hearings open).
2. Section 47 (sexual misconduct witnesses).
3. Section 48 (transcript of hearings). 1991, c. 18, Sched. 2, s. 22 (3).

Same

(3.1) The following provisions of the *Statutory Powers Procedure Act* also apply with necessary modifications to a review by the Board:

1. Section 21.1 (correction of errors).

2. Section 25.1 (rules). 1998, c. 18, Sched. G, s. 12.

Findings of fact

(4) The findings of fact in a hearing shall be based exclusively on evidence admissible or matters that may be noticed under sections 15, 15.1, 15.2 and 16 of the *Statutory Powers Procedure Act*. 1991, c. 18, Sched. 2, s. 22 (4); 2007, c. 10, Sched. M, s. 27 (1).

Idem

(5) The findings of fact in a review shall be based exclusively on the application and documentary evidence admissible or matters that may be noticed under sections 15, 15.1, 15.2 and 16 of the *Statutory Powers Procedure Act*. 1991, c. 18, Sched. 2, s. 22 (5); 2007, c. 10, Sched. M, s. 27 (2).

Disposal by Board

(6) The Board shall, after the hearing or review, make an order doing any one or more of the following:

1. Confirming the order made by the panel.

2. Requiring the Registration Committee to make an order directing the Registrar to issue a certificate of registration to the applicant if the applicant successfully completes any examinations or training the Registration Committee may specify.

3. Requiring the Registration Committee to make an order directing the Registrar to issue a certificate of registration to the applicant and to impose any terms, conditions and limitations the Board considers appropriate.

4. Referring the matter back to the Registration Committee for further consideration by a panel, together with any reasons and recommendations the Board considers appropriate. 1991, c. 18, Sched. 2, s. 22 (6); 2007, c. 10, Sched. M, s. 27 (3).

Idem

(7) The Board may make an order under paragraph 3 of subsection (6) only if the Board finds that the applicant substantially qualifies for registration and that the panel has exercised its powers improperly. 1991, c. 18, Sched. 2, s. 22 (7).

Limitation on order

(8) The Board, in making an order under subsection (6), shall not require the Registration Committee to direct the Registrar to issue a certificate of registration to an applicant who does not meet a registration requirement that is prescribed as a non-exemptible requirement. 1991, c. 18, Sched. 2, s. 22 (8).

Parties

(9) The College and the applicant are parties to a hearing or review. 1991, c. 18, Sched. 2, s. 22 (9).

Business Name Registration

2014

Under paragraph 2.(2) of the *Business Names Act*, “no individual shall carry on business or identify his or her business to the public under a name other than his or her own name unless the name is registered by that individual.” If you are practising as a sole practitioner under your own name, you are not required to register your business name. If your business name is other than your name(s), you must register your business name with ServiceOntario.

You may obtain further information and register online at:
https://www.ontario.ca/page/business-name-registration

Discontinuation of Service

Revised: Aug. 2009

If you feel you are no longer able to provide care to a patient, for example the patient is abusive to you or your staff, or you learn that the patient has lied to you and you feel you have lost the trust necessary to provide care, it is possible for you to discontinue services. However, in doing so you must ensure that the requirements under the *Optometry Act* are met prior to discontinuance. Ontario Regulation 119/94 defines the discontinuance of professional services that are needed as an act of professional misconduct, unless,

i. the patient requests the discontinuation,
ii. alternative services are arranged, or
iii. the patient is given a reasonable opportunity to arrange alternative services.

You may discontinue services pending payment of an outstanding account for services already provided, unless the needed services are of an emergency nature.

If you are initiating the discontinuation and you choose to arrange alternative services, this should be done in the same manner as making a referral by contacting the other practitioner and providing either copies of your clinical records or a summary report of the care that you provided. As an alternative to this, you may give your patient notice that on a specific date in the future you will no longer provide care and that in the meantime he or she would be well advised to seek the services of another practitioner. In setting the specific date after which your services will no longer be provided, you should be sensitive to such factors as the local availability of care and your patient's ability to travel as well as his/her clinical condition. You should also be prepared to provide either copies of your clinical records or a summary report of your care to the patient’s new

optometrist. In either situation where you have initiated the discontinuation of service, it would not be appropriate to charge the patient for forwarding copies of the clinical records or preparation of a report.

When you initiate discontinuation of services, it is critical to make the patient understand that it is in his/her best interest for you to transfer care to another practitioner. If appropriate, inform the patient that you will transfer their file to the practitioner of their choice. Above all, remember to maintain your professionalism throughout the period of transition.

Incorporation: Obtaining a Certificate of Authorization for a Professional Corporation

Revised: Aug. 2009

The process of incorporation for health professionals is unique to them and it is recommended that members consult with a lawyer familiar with health regulatory law and with an accountant prior to completing an application for a Certificate of Authorization.

As a result of amendments to the *Regulated Health Professions Act* (RHPA) (including regulations), the *Health Professions Procedural Code* and the *Business Corporations Act* (BCA), regulated health professionals are now permitted to incorporate for the purpose of practising a health profession, providing they obtain Certificates of Authorization from their respective health profession Colleges. The new provisions outline the conditions and requirements that must be met in order to obtain a Certificate of Authorization from a College. A complete information package and application form are available on the College website at **www.collegeoptom.on.ca.**

Independent Contractor

Regulatory Standards (O. Reg. 119/94 Part II Conflict of Interest under the Optometry Act) Interpreted

(Effective April 15, 2014)

NB: This document does not apply to associate agreements with other optometrists or physicians where both owner(s) and associate(s) practice together (although these associate optometrists may be considered "independent contractors" by the CRA for tax purposes).

“Independent contractor” means a person who practises optometry under an agreement with another, but who is independent and not controlled by the other or subject to the other’s right to control respecting the member’s conduct in the practice of optometry.

Optometrists are limited as to the types of practice relationships into which they may enter. Where optometrists are engaged in the practice of optometry with anyone other than another optometrist or a physician (or working in other arrangements as allowed by the regulation), optometrists are required to do so as independent contractors. An independent contractor must have a written agreement which states that the optometrist,

- controls the professional services provided to a patient;
- controls who he or she may accept as a patient;
- provides every patient with a copy of his/her prescription;
- sets the fee charged or collected in respect of any professional service;
- controls the maintenance, custody and access to optometric patient records;
- has access, along with the optometrist’s staff, to the premises, books and records at any time of day or night; and
- ensures that any advertising related to professional services provided by the optometrist is compliant with Ontario Regulation 119/94 (as amended by Ontario Regulation 24/14 made under the Optometry Act (the “Regulation”)).

Professional services: It would be considered a conflict of interest for optometrists to be engaged in practice where a third party restricts their access or ability to provide professional services to their patients. For example, if optometrists cannot provide optometric services to a certain demographic of the population as a condition of the agreement with the corporation, or if optometrists are not allowed to refer patients to another practitioner for visual field testing, optical coherence tomography, or corrective surgery, where it is clinically indicated.

Who may be accepted as patients: In some corporate settings, there is a requirement that clients be “members” in order to access the services of the corporation. Optometrists practising in such a setting should have in their agreement a statement that everyone may access their services, regardless of whether or not they are a “club member”.

Provide all patients with a copy of their prescription: Optometrists, or their staff, must provide patients with a copy of their prescription. For example, optometrists practising as independent contractors in an optical location should

provide prescriptions to patients directly, and not “hand-off” prescriptions to the staff of the optical.

Charging Fees: The College considers that optometrists who are working with a corporation but do not have control over the setting and collecting of fees (where the fees are set by the corporation and are consistent across the corporation), are not independent contractors and would be practising in a conflict of interest. This is not to restrict optometrists from having others collect fees on their behalf (such as shared staff), however optometrists must have control over the amount, how and when fees are collected on their behalf.

Maintenance, Custody and Access to Records: Where optometrists are practising as independent contractors with an optician/optical store, every practitioner is the health information custodian for their own patient records. In an independent contractor arrangement, the College would take the position that the optometrist, in controlling the maintenance, custody and access to the records, would keep the records separate from the optical records. Accordingly, if optometrists leave the practice setting, they would have the right to relocate the optometric records. Optometrists would be obligated to inform patients that the records have been relocated. Arrangements where optometrists do not have unfettered access to, and control of, their patient health records would be considered a conflict of interest.

Access to Premises: Optometrists must be able to provide care to patients in extraordinary circumstances (e.g. in an emergency) should it be necessary. Accordingly, optometrists working as independent contractors with a corporation (for example a large retail entity) must have a system to access their office at all hours.

Advertising: Optometrists are no longer prohibited from advertising with non-members, therefore optometrists practising as independent contractors may advertise with non-optometrists. Advertising must be in accordance with the advertising regulations and guidelines and must not, for example, contain testimonials, superlatives or comparatives. Any advertising of the optometrist’s practice, whether or not the optometrist directly placed the ad, is the responsibility of the optometrist and must comply with the advertising regulation. For example, if an optical advertised “TZVEC Optical has the best glasses in town,” and also included a reference to an independent contractor “Eye examinations provided by Dr. X onsite,” the College considers that Dr. X would be in violation of the advertising regulation, knowingly permitting the publication of an advertisement that includes a superlative.

<u>Additional Considerations</u>

Associate Optometrists: Where multiple optometrists practice at the same optical/corporation, each optometrist must have a separate independent

contractor agreement with the optical/corporation. An exception to this would be if one or more of the optometrists acting as independent contractors and who have agreements with the optical/corporation, employ associate optometrists. In that case, the optometrists who enter into the agreement as independent contractors will be responsible for ensuring that the associates are not controlled by the optical/corporation and that the provisions of the agreement are respected. In the event of a breach of the independent contractor requirements resulting from the optical/corporation controlling the associate, it is the independent contractor who will be held responsible.

To employ associate optometrists, independent contractors in the above scenario must also practice optometry at the optical/corporation location in order to meet the definition of "independent contractor". Optometrists cannot be merely an administrator, figure head, or in practice full-time at a different location(s) because they would not be practising optometry at the location in question.

Rental Arrangements: It is appropriate for written agreements between independent contractors and optical/corporations to include reasonable terms regarding facility and equipment costs, and shared staff. Independent contractors, who receive free rent, equipment use or shared staffing, would be considered in a conflict of interest. This is because such arrangements are likely to influence the optometrist's professional expertise or judgment, or if there is any connection between the "free" rent, equipment or services and the referral of patients by the member to the optical/corporation, it would constitute a benefit for the referral of patients which is contrary to the Regulation .

The College may require evidence of the independence of members and proof that appropriate payments of rent, equipment and/or services are being made. This may include the independent contractor agreements, cancelled rent cheques, financial statements or other documents. It is also considered a conflict of interest for optometrists to enter into arrangements where the rent is based on the amount of fees charged or the volume of business.

Fee Sharing: Optometrists are prohibited from sharing fees with anyone except other optometrists or physicians. An offer of "free eye exams" by optometrists may involve fee sharing with the optical/corporation and would constitute a conflict of interest as members may only share fees with other members and physicians.

In addition, advertising "free eye exams" is false or deceptive and is contrary to the advertising provisions in the Regulation. It may also constitute criminal fraud if OHIP is being billed for the examination.

College May Request Evidence of Compliance: The College may request that members practising in an optical/corporation setting produce their written agreements to the College for the purpose of verifying their status as

independent contractors. It is not sufficient that independent contractors have an agreement in place; they must actually work in accordance with its terms. The College may require verification that this is happening.

Independent Contractor:

Risk & Control

June 2015

NB: This document does not apply to associate agreements with other optometrists or physicians where both owner(s) and associate(s) practice together (although these associate optometrists may be considered "independent contractors" by the CRA for tax purposes).

Since the revised Professional Misconduct Regulation, Ontario Regulation 119/94, came into force in April 2014, members have been regularly contacting the College with questions about the independent contractor relationship. Two important considerations in determining whether an optometrist is an independent contractor are risk and control. Optometrists who practise as independent contractors operate their own businesses and must take responsibility for doing so. This means that they bear the financial risk of the practice, along with the corresponding opportunity to profit, and have control of the practice. If they do not, they will be in a conflict of interest.

Risk

One of the primary financial risks that an independent contractor must accept is the overhead expense related to the operation of his/her practice. A signed independent contractor agreement must therefore include terms for reasonable rent. Reasonable rent should be calculated based on considerations that include, but are not limited to,

- area (ft^2) of space used;
- equipment provided by the corporation (usually fixed equipments);
- utilities; and
- shared staffing.

Rent cannot be related to the volume of business conducted, and therefore cannot be paid daily, weekly, or irregularly. Rental terms must be fixed and involve regular payments, typically monthly and without interruption.

If a rental agreement is not calculated with consideration to the above, the optometrist would not be considered an independent contractor and could be considered in conflict of interest.

Control

Members must control all aspects of their practice to be independent contractors. This includes setting the fees they charge, deciding who they accept as patients, storage and maintenance of records, the hours and days they work and vacation time.

Conduct trumps Contract

Simply putting the required terms from the Regulation (O. Reg. 119/94) in a contract is not sufficient to comply with the conflict of interest provisions. Independent contractor optometrists must act in keeping with their contracts and actually practice independently to demonstrate that they are not practising in a conflict of interest.

Optometrists working as independent contractors may be asked by the College at any time to provide a copy of their written agreement, along with proof that they are acting in accordance with the agreement. In cases related to conflict of interest, the ICRC has already required members to submit independent contractor agreements and proof of rent payment for verification.

The College will consider an optometrist who has assumed no financial risk in his or her practice or who has no or limited control of his or her practice to be in conflict of interest. This is professional misconduct and such allegations can be referred to the Discipline Committee.

Additionally, the Canada Revenue Agency (CRA) may consider an optometrist without risk or control in his or her practice to be an employee, not an independent contractor. Such a determination by the CRA may lead to financial penalties to the optometrist and/or the corporation. Recently in Ontario, CRA has conducted audits of physiotherapy clinics. In some cases physiotherapists who believed that they were working as independent contractors were found to be employees. CRA concluded that they did not bear enough financial risk or have enough control of their businesses. The physiotherapists and clinic owners were

ordered to pay penalties as well as retroactive income tax, CPP and EI deductions.

More information about independent contractor and conflict of interest provisions under the *Optometry Act* can be found on the College website.

Mandatory Reporting: Health Card Fraud

Bulletin, Feb. 2002

Under the *Health Insurance Act* (HIA), an optometrist is obliged to file a report when “in the course of his or her professional or official duties, has knowledge" that any of the following activities have occurred:

i. an ineligible person receives or attempts to receive an insured service as if he or she were an insured person,
ii. an ineligible person obtains or attempts to obtain reimbursement by the Ontario Health Insurance Program (OHIP) for money paid for an insured service as if he or she were an insured person, or
iii. an ineligible person, in an application, return or statement made to OHIP or the General Manager gives false information about his or her residency.

The HIA extends the reporting requirements to employees of optometrists who may become aware of the fraud. In cases where reporting of health card fraud arises, the optometrist, or his or her employee, is required to make the report promptly to the General Manager of OHIP.

Missed Appointments

Bulletin, Feb. 2004

Q: Can I charge a patient who does not show up for an appointment?

A: Yes, you may charge a patient for a missed appointment but only if the patient has been advised, in advance, that there would be a charge. Even if the patient has been advised, whether or not you do charge in any given situation may depend on the circumstances. Below are some factors that you may want to consider.

- Whether this is the first time that the patient has missed an appointment or if it is part of a pattern.
- The circumstances surrounding the missed appointment. Poor weather may make it difficult or impossible for even well-intentioned patients to

attend appointments. Some illnesses (the flu, for instance) may strike suddenly.
- Whether or not you were readily available for the patient to contact the office to advise of a scheduling problem.

Non-Practising Fee Administration Policy

Effective Date: January 16, 2017

Overview
The College Council approved a reduction of 50% in member annual fees for non-practising members effective for the 2017 annual renewal period at its January 16, 2017 Council meeting.

Administration of Non-Practising Fee

1. Members who were in the College member database as being non-practising by 11:59 pm on January 16, 2017, should have paid member annual fees reduced by 50% for the 2017 annual renewal period.

2. Members who wish to change their status from “practising” to “non-practising”, or from “non-practising” to “practising” on or after January 16 2017, will be charged an administrative fee of $105.00 plus HST for a total of $118.65 every time they wish to change their status.

3. There will be no refunds due for Members who wish to change their status from “practising” to “non-practising”.

4. Members who wish to change their status from “non-practising” to “practising” after January 16, 2017, will be charged an administrative fee as described above, in addition to a prorated portion of 50% of a full practising member annual fee.

5. If the request by the member to change status from “non-practising” to “practising” was received by the College before or on the 15th day of the month, the prorated portion of 50% of a full practising member annual fee would include the month that the request was received. If the request by the member was received by the College after the 15th day of the month, the prorated portion of 50% of a full practising member annual fee would not include the month the request was received. Please refer to Schedule A below.

6. Members who wish to change their status to “non-practising”, must first complete, sign, and return the undertaking in Schedule A associated with the College’s Non-Practising Status policy to the College. In accordance with the College’s Non-Practising Status policy, a member who fails to

submit the completed and signed undertaking will continue to be subject to the conditions of registration with the College, including the practice hour requirement.

a) Newly registered members

7. While the College discourages new applicants from initial registration as non-practising status, it is allowed for newly registered members to secure a practice location following registration. For those new members who must initially register as non-practising, the College encourages them to secure a practice location within a maximum six months to change their status to “practising”.

8. Newly registered members who were registered as “non-practising” prior to the 2017 membership renewal period and who have been members of the College less than one full year by January 1, 2017, will have until June 30, 2017, to have their status changed to “practising” after first satisfying the College’s requirements for changing status unless they submit proof to the College that they are currently practising in other Canadian provinces in which case they would be permitted to remain “non-practising”.

9. Should newly registered members wish to change their status to “practising” by June 30, 2017, the administrative fee of $118.65, will be waived.

Schedule A: How prorated portion of a member’s annual fee is calculated

Examples: If request to change from “non-practising” to “practising” is received by the College before or on:

a) February 15, 2017, prorated portion due: administrative fee + 11 * (50% of annual member fee)/12
= $118.65 + $533.93 *11/12
= $608.09

b) March 15, 2017, prorated portion due would be: administrative fee + 10 * (50% of annual member fee)/12
= $563.59

Examples: If request to change from “non-practising” to “practising” received by the College after:

c) April 15, 2017, prorated portion due: $118.65+ $533.93 * 8/12
= $474.60

d) October 15, 2017, prorated portion due: $118.65 + $533.93 *2/12

= $207.64

e) December 15, 2017, prorated portion due: $118.65

Registration Policy: Non-Practising Status

Approved by Council, January 20, 2016

Purpose

The purpose of this policy is to establish a fair process for members who are not practising in Ontario, but wish to maintain their registration with the College, while ensuring the delivery of the highest quality of eye care in the public interest.

Scope

This policy applies to all members of the College of Optometrists of Ontario (the "College").

Background

There are two classes of membership with the College: (1) general and (2) academic. The College does not have an inactive or non-practising class of membership.

It is a condition of registration for both the general and academic classes of membership that a member must provide at least 750 hours of direct optometric care to patients in Canada in every three-year period (Registration Regulation, s. 7). If a member holds an appointment at the School of Optometry of the University of Waterloo or other optometric educational facility in Ontario approved by the Council, the member may apply to the Registration Committee for an exemption from the practice hour requirement on the basis that the member's academic duties prevented the member from meeting the requirement. The Registration Regulation does not provide for any other exceptions to the practice hour requirement.

If a member does not meet the practice hour requirement and has not been exempted from it, the Registrar must refer the member to the Quality Assurance Committee for a practice assessment (in accordance with the Registration and General Regulations). A practice assessment may include the inspection and assessment of records, an inspection of the member's office and a practice questionnaire. If the Quality Assurance Committee finds deficiencies in the member's practice, the Committee can make recommendations, require the member to complete continuing education activities or require the member to undergo a clinical evaluation. Following a clinical evaluation, the Quality

Assurance Committee may require the member to complete a more comprehensive remedial program or impose terms, conditions and limitations on the member's certificate of registration (General Regulation, ss. 27-29).

The purpose of the practice hour requirement is to ensure that practising optometrists remain current and up-to-date in their ability to practise the profession safely and competently. Nevertheless, the College recognizes that members may need or want to stop practising in Ontario for a variety of personal and professional reasons. Those members may not want to resign their membership with the College. Accordingly, the College has developed this policy to establish the process to follow when a member requests non-practising status with the College, as well as the steps that are required for a member with non-practising status to return to practise in Ontario.

Policy

What is Non-Practising Status?

As noted above, the College does not have a non-practising or inactive certificate of registration. Non-practising status is recognition that a person is still a member of the College but has agreed not to practise optometry in Ontario unless certain conditions are met. The member's entry on the College's public Register will state "Member Non-Practising".

Non-practising status is voluntary. However, if a member does not request non-practising status, that member will continue to be subject to all of the conditions of registration with the College, including the practice hour requirement.

Requesting Non-Practising Status

A member may change his or her status from practising to non-practising by signing and delivering an undertaking to the College in the form attached as Appendix A. In order to obtain non-practising status, the member must agree to:

- not practise optometry in Ontario while the member has non-practising status;
- provide information to the College, renew his or her certificate annually and pay all fees required under the *Optometry Act*, the Regulations and the College's By-laws;
- fulfill the mandatory continuing education requirements of the Quality Assurance Program;
- have the fact of the undertaking posted on the College's public Register;
- if the member has not provided any direct optometric care to patients in Canada in the three years before the member's request to return to practise, complete a practice evaluation prior to returning to practise. The

member will also have to comply with any orders of the Quality Assurance Committee arising out of the practice evaluation;
- if the member has provided some hours of direct optometric care, but less than 750, to patients in Canada in the three years before the member's request to return to practise, complete a practice assessment within six months of returning to practise.

Upon receipt of an acceptable undertaking, the College will change the member's status to nonpractising, notify the member of the change in writing and update the public Register.

If a member does not sign an undertaking and does not resign, the member will remain subject to all of the conditions and obligations of membership with the College, including the practice hour requirement. In other words, if a member has not signed an undertaking and does not meet the practice hour requirement in a three-year period, that member will be referred to the Quality Assurance Committee for a practice assessment.

Returning to Practising Status from Non-Practising Status

A member may request to return to practising status in accordance with the terms of the undertaking he or she has provided to the College. The member must first complete a Return to Practise Form (including a declaration of hours of practice in the current year and statement of good standing), provide proof of liability insurance, and complete the Practice Location/Change of Information Form.

In accordance with the terms of the member's undertaking, the member may be required to complete a practice assessment or practice evaluation depending on the number of practice hours the member provided in the three years before his or her request to return to practise. Specifically:

- If the member has provided at least 750 hours of direct optometric care to patients in Canada in the three years before the member's request to return to practise, no further action is required.
- If the member has provided less than 750 hours of direct optometric care to patients in Canada in the three years before the member's request to return to practise, the member will be required to successfully complete a practice assessment within the first six months after returning to practise.
- If the member has not provided any hours of direct optometric care to patients in Canada in the three years before the member's request to return to practise, the member will be required to successfully complete a practice evaluation and comply with any orders of the Quality Assurance Committee prior to returning to practise.

Summary of Steps for Return to Practising Status:

Member met practice hour requirement in last 3 years	***Member provided less than 750 hours of patient care in Canada in last 3 years***	***Member has not practised at all in Canada in last 3 years***
1. Complete Return to Practise Form (including a declaration of hours of practice in the current year and statement of good standing)	1. Complete Return to Practise Form (including a declaration of hours of practice in the current year and statement of good standing)	1. Complete Return to Practise Form (including a declaration of hours of practice in the current year and statement of good standing)
2. Provide proof of liability insurance	2. Provide proof of liability insurance	2. Provide proof of liability insurance
3. Complete the Practice Location/Change of Information Form	3. Complete the Practice Location/Change of Information Form	3. Complete the Practice Location/Change of Information Form
	4. Participate in practice assessment within 6 months after returning to practise	4. Participate in practice evaluation under the Quality Assurance Committee and comply with any orders of the Quality Assurance Committee, prior to return to practise

The College strives to process Return to Practise applications in a timely manner. However, the College urges members to consult with the College prior to making any practice arrangements.

References to Relevant Legislation

Registration Regulation, O. Reg. 837/93 under the *Optometry Act, 1991*, S.O. 1991, c. 35: section 7

General Regulation, O. Reg. 119/94 under the *Optometry Act, 1991*, S.O. 1991, c. 35: sections 23-34

Appendix A: Non-Practising Status Undertaking
College of Optometrists of Ontario
Acknowledgement and Undertaking of

_____ **[name of Optometrist]**

1. I, _____, am a member of the College of Optometrists of Ontario (the "College").

2. I hold:

☐a general certificate of registration with the College.

OR

☐an academic certificate of registration with the College.

3. I am requesting non-practising status with the College effective: ☐immediately.

OR

☐_____ /_____ /_____.
[day/month/year]

4. I am voluntarily providing this undertaking in exchange for the College granting me nonpractising status.

5. While my registration status is non-practising, I undertake as follows:

a. I will not practise optometry in Ontario;
b. I will renew my certificate of registration annually;
c. I will pay all fees required of me under the *Optometry Act*, the Regulations and the College's By-laws;
d. I will comply with the mandatory continuing education requirements of the College's Quality Assurance program;
e. I will submit a completed member report annually in accordance with the College's By-laws;
f. If the College requests information of me, I will respond to the College in a timely manner and provide the requested information; and
g. I will notify the Registrar in writing of any change to information that I have previously provided to the College.

6. I acknowledge and agree that my registration status and the details of this undertaking will be posted on the College's public Register.

7. Prior to my return to practise in Ontario, I undertake to:

   a. Notify the Registrar in writing by submitting a completed Return to Practise form to the College;
   b. Submit proof of my liability insurance to the College; and
   c. Submit a completed Practice Location/Change of Information Form to the College.

8. I undertake that I will not resume practising optometry in Ontario until I have been notified in writing by the Registrar of my authorization to do so.

9. I acknowledge that the Registrar will authorize my return to practise in accordance with the following process:

   a. If I have provided at least 750 hours of direct optometric care to patients in Canada in the three-year period before the date of my signed Return to Practise Form, I acknowledge that no further action will be required of me.

   b. If I have not provided <u>any</u> hours of direct optometric care to patients in Canada in the three-year period before the date of my signed Return to Practise Form, I undertake to comply with and fulfill the following:

      i. I will participate in a practice evaluation under the Quality Assurance program prior to my return to practise. I acknowledge that as part of the practice evaluation, I may be required to, among other things, answer oral or written questions that relate to practising optometry; answer oral or written questions that arise from a review of real or simulated patient charts; examine persons or clinical simulations exhibiting problems that relate to practising optometry; and demonstrate the application of optometric techniques;
      ii. I will comply with any orders made by the Quality Assurance Committee arising out of the practice evaluation in accordance with the College's General Regulation, O. Reg. 119/94; and
      iii. I will pay all costs related to the practice evaluation and any orders of the Quality Assurance Committee.

c. If I have provided some direct optometric care to patients but less than 750 hours of direct optometric care to patients in Canada in the three-year period before the date of my signed Return to Practise Form, I undertake to comply with and fulfill the following:

i. I will participate in a practice assessment under the Quality Assurance program within the first six months of my return to practise. I acknowledge that the practice assessment may include, but is not limited to, the inspection of my practice location; the inspection of approximately 25 patient charts; and the completion of a practice questionnaire. I acknowledge that the Quality Assurance Committee may make recommendations to me; require me to complete continuing education activities; or require me to undergo an evaluation of my clinical ability in accordance with the College's General Regulation, O. Reg. 119/94; and ii. I will pay all costs related to the practice assessment.

10. If I am dissatisfied with any decision of the Registrar made under this Acknowledgement and Undertaking, I may request, in writing, that a panel of the Registration Committee review that decision.

11. I have read this Acknowledgement and Undertaking and understand my obligations under it. I have had an opportunity to seek independent legal advice and have either done so or decided not to seek such advice. I am signing this Acknowledgement and Undertaking voluntarily.

Signed at _____[City], this ___ [Date] day of _____[Month], _____[Year]

_____	_____
Signature of Member	Signature of Witness
_____	_____
Printed Name of Member	Printed Name of Witness

Date Received at College: _____

Practice Locations – Reporting Requirements

The College By-Laws require members to provide written notice of any change to information previously provided to the College within 14 days of the change. This includes notifying the College of any change of practice location or any additional locations where a member may practise.

An optometrist must report a location to the College if it meets one or more of the following criteria:

- practise or plan to practise 14 or more days per year or four or more days in any one month in that location;
- the clinical records are maintained on-site; or
- there is published contact information related to or referencing the location.

Effective date: April 15, 2014

Prevention of Sexual Abuse in Optometric Practice

Bulletin

Introduction

The College of Optometrists of Ontario views any form of abuse of a patient, whether sexual or otherwise, as professional misconduct that will not be tolerated. The *Regulated Health Professions Act, 1991 (RHPA)* and the Health Professions Procedural Code (the Code) set out specific requirements for the manner in which the College deals with sexual abuse and provides severe sanctions for members who are found to have sexually abused a patient. This advisory sets out the legislated standards of conduct that are required of members, and provides guidelines to assist members in avoiding allegations of sexual impropriety.

The College's Patient Relations Program

The *RHPA* requires every regulated health profession's college to have a Patient Relations Program that includes measures for preventing and dealing with sexual abuse of patients. The measures must include educational requirements, guidelines for the conduct of members with their patients, training for College staff and provision of information to the public. The primary responsibility for the Patient Relations Program lies with the College's Patient Relations Committee.

Definition of sexual abuse

Sexual abuse is defined in the Code as:

a) sexual intercourse or other forms of physical sexual relations between the member and the patient;
b) touching, of a sexual nature, of the patient by the member; or
c) behaviour or remarks of a sexual nature by the member towards the patient.

According to the Code, touching, behaviour or remarks of a clinical nature appropriate to the services provided are not considered to be touching of a 'sexual nature'.

Discipline and Penalties

If a member is found to have committed an act of conduct by sexually abusing a patient, sanctions imposed by a panel of Discipline Committee may include any or all of the following:

- revoking the member's certificate of registration:
- suspending the member's certificate of registration for a specified period of time;
- imposing specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time;
- reprimanding the member;
- requiring the member to pay a fine of up to $35,000;
- requiring the member to reimburse the College for the cost of therapy; and counseling provided for the sexually abused patient under a program established by the College.

If the sexual abuse consisted of or included:

- sexual intercourse;
- genital to genital contact (genital to anal, oral to genital, or oral to anal);
- masturbation of the member by, or in the presence of, the patient;
- masturbation of the patient by the member;
- encouragement of the patient by the member to masturbate in the presence of the member

a panel of the Discipline Committee is required by the Code to:

- **revoke, for a minimum of five years,** the members certificate of registration;

and

- **reprimand the member.**

In addition, the optometrist may be fined up to $35,000 and be required to reimburse the College for the cost of therapy and counselling provided for the sexually abused patient under a program established by the College.

Prevention

Members need to be exceptionally careful in their interaction with patients to ensure that their behaviour is not misinterpreted. Suggestive comments, profanity or sexual jokes may be misunderstood and could lead to allegations of professional misconduct. Optometrists should be aware of how their behaviour may be perceived by the patient as well as anyone who may observe or overhear the interaction.

Members should also be aware that patient expectations differ based on cultural background, religion, gender, age, and sexual orientation. Accordingly, a high level of respect and sensitivity is required to ensure that people of all backgrounds are treated with dignity.

The College advises all members to take a second look at their behaviour, be alert to the potential for allegations of sexual impropriety and, where necessary, change their behaviour.
The following advice is provided to assist members in avoiding allegations of sexual impropriety or sexual abuse:

• Having a patient disrobe is never appropriate.
• Hugging and kissing is inappropriate and should never be initiated by the optometrist.
• Touching should only be used as necessary to facilitate the optometric examination. Physical assistance may be required to facilitate patient positioning and head, eyelid or brow manipulation for ocular examination.
• Reclined patient positioning for examination may make a patient feel vulnerable. The reason for reclining the patient should be explained, and consent obtained.
• Comforting or reassuring a nervous or upset patient should be done with words rather than with touch.
• Appropriate touching for greeting purposes (such as shaking hands) or for assisting in the transfer of patients (for example from a wheel chair to examination chair), may enhance the comfort of a patient.
• Face to face proximity as is required in direct ophthalmoscopy should be explained. Patient and doctor comfort may be enhanced through the use of a face mask.
• Questioning and conversation must avoid references to sexual practices, thoughts, and orientation except where necessary, as in cases of diagnosis and treatment of ocular manifestations of sexually transmitted disease.
• Do not comment on a patient's appearance, clothing, or body unless clinically necessary.
• Do not tell jokes or stories of a sexual nature.
• Do not display material within the office that is sexual or suggestive, or may be offensive to patients or staff.
• Ensure that a member of the office staff or a third party is in attendance when

services are performed within the optometry office outside of normal office hours.

If a patient initiates sexually inappropriate conversation or behaviour, this should be respectfully discouraged and a record of the incident made. Having a staff member of third party in attendance throughout the examination may help prevent misunderstanding or accusation. If the patient persists in the inappropriate behaviour, the optometrist should end the optometrist/patient relationship by dismissing the patient.

Because of the power differential in the optometrist/patient relationship, it is always the responsibility of the optometrist to maintain appropriate boundaries. Sexual activity between an optometrist and a patient, even if perceived as consensual by those involved, is by definition considered to be professional misconduct.

Dating patients

Because of the broad definition of sexual abuse in the *RHPA,* it is problematic for an optometrist to have a social relationship with a current patient. There are different types of social engagements that may be considered “dating", however professional misconduct occurs whenever a relationship with a patient involves behaviour or remarks of a sexual nature.

There are ethical dilemmas beyond the potential for sexual abuse allegations that may arise when dating a patient. The best course of conduct for members is to avoid dating any current patient. If an optometrist intends to date a patient, he or she should first terminate the patient/practitioner relationship by dismissing the patient.

The *RHPA* does not provide exemption from the sexual abuse provisions for a spouse who is also a patient.

Sexual harassment of office staff

While not dealt with in the *RHPA*, any form of harassment (sexual or otherwise) of office staff, including professional associates, may lead to allegations of professional misconduct.

A staff member who has received assessment or treatment services from an optometrist is considered to be a patient for the purpose of applying the sexual abuse provisions of the RHPA.

Mandatory Reports

If, in the course of practicing the profession, an optometrist obtains reasonable grounds for believing that another regulated health professional has sexually

abused a patient, the optometrist must make a report to the Registrar of the College of which the alleged abuser is a member. The report must be made within 30 days of obtaining such information and must contain the name of the reporter, the name of the alleged abuser, the details of the alleged abuse, and the name of the patient (but only if the patient consents in writing to the inclusion of his or her name in the report).

Professional Liability Insurance

***Bulletin*, Nov. 2003**

It is a condition on every certificate of registration that the optometrist obtains and maintains professional liability (malpractice) insurance. This condition is seen as protecting both members and the public alike. It protects members in the event of an untoward incident: the Insurer will cover the costs of defense and any payment ordered by the Court in the event of a large payout, having insurance could save a member from financial ruin. This condition is also seen as protective of the public. It is felt that, again, in the event of a large award made to a patient, the insurer would be in a better financial position to make the payment.

The College Bylaw with respect to professional liability insurance is as follows:

11.1 A member who engages in the practise of optometry in Ontario shall maintain professional liability (malpractice) insurance, in a form acceptable to the College, of not less than

> *i $2, 000,000 per occurrence; and*
> *ii. $5,000,000 per year in the aggregate.*

11.1.1 The policy of insurance shall

> *i have a deductible of not more than $5,000 per occurrence, and*
> *ii. continue to provide coverage for (occurrences which took place when the policy was in effect despite the fact that the insured was not a member or did not have coverage in effect when he or she first became aware of the existence of the claim.*

Records: Patient Access after Relocation or Retirement

Revised: Aug. 2009

When an optometrist changes offices or retires from practice, patients have a right to expect that information in their clinical records will be available to them. You have obligation to make arrangements with your patients for access to or transfer of their records when you relocate your office or retires from practice.

There are a number of ways that this may be accomplished. However, you are reminded that such records are confidential, that in the case where you retain the records then patients should be aware of how to contact you, and, in the case where you have transferred your files to another optometrist, patients should be informed of this transfer. You should have an understanding with the optometrist receiving the records that he or she will give you access to those records in the future should that be required.

Records: Practice Breakup

Council, Nov. 2003

From time to time, the College becomes involved in issues relating to access to records. The law is clear that patients have the right to access the information contained in their clinical records. This right to access usually includes reviewing the record, obtaining a copy of the record or directing that a copy of the record is sent to another practitioner. This right to access is relatively straightforward when there is only one practitioner involved. However, it becomes more complicated when two or more practitioners are practicing together, and there is a practice break-up. In these cases, either one or more of the patient, the departing practitioner(s) or the remaining practitioner(s) ask for the College's position on who "owns" the records. In many of the cases that are brought to the attention of the College, there is no written agreement between practitioners as to what will happen with respect to the records upon dissolution of the practice.

In order to be assistive to members in understanding what their rights and obligations are in situations where there is a practice break-up, the Council has adopted the following Guidelines for members:

- Patients have a right to access the information on their health records including direction their health records including directing information be sent to another practitioner, and this right to access should not be impeded by business agreements.

The delivery of quality care relies on access to historical information. Optometrists practicing in multi-practitioner settings, either with other optometrists or other health care practitioners, are encouraged to have business agreements that deal with who regains control and custody of patient records if the business relationship is dissolved. Nevertheless, Council considers that it is inappropriate for there to be a clause that attempts to limit a patient’s right to either access the record or direct that the information in the record be transferred to another practitioner.

- Business agreements between practitioners should not impede a patient’s right to choose a practitioner to deliver services including being provided with contact information when this is requested.

Patients have the right to choose the practitioner that they want to provide their care. The College believes that it is inappropriate for optometrists to enter into a business relationship wherein the flow of information about the whereabouts of another member is restricted. This is more than a matter of policy, since failure to provide contact information to a patient about a practitioner who previously practiced with the member may be a matter of professional misconduct.

- Patients have a right to know where their health records are stored, and who has access to them.

Recognizing that quality care relies on access to historical information, patients have a right to know where their records are located. It is reasonable for a patient to assume that the records will be retained in the practice where she/he was examined. If for some reason the records are re-located elsewhere, reasonable attempts to contact and inform the patients should be made. The nature and extent of the attempts may vary depending on the circumstances. For instance, in small communities, placement of a notice in the daily or weekly paper on several occasions may suffice.

- There is no inherent right for an associate working in a practice to have access to patient information, nor is there an inherent responsibility for a practitioner with primary responsibility for the records to provide patient information to the associate if the associate leaves the practice.

Optometrists working in another optometrist's practice as an employee or as an associate have no inherent rights to access any information about the patients he or she saw in that practice. Records, including clinical and contact information, belong to the practice and to the owner(s) of the practice. Any patient information may only be released with the consent of the patient, or as required by law. Where two (or more) members are in a cost sharing arrangement ownership of the records will remain separate; that is, each member will retain ownership of the records he/she made.

- Members working together should have business agreements that spell out the rights and responsibilities of each party in the event of a practice break-up. The contract may specify an associate's right to certain information retained by the practice and/or an owner's obligation to provide it.

Ideally, many problems would be avoided if members documented their business agreements. Such documentation should be done with legal advice and include the respective roles and responsibilities of all involved parties, including those relating to ownership and access to records.

• When a patient consents to the transfer of files upon a practice break up, it is the responsibility of the requesting practitioner (or patient) to cover the costs associated with the transfer of the records.

Members are urged to refer to the OAO Suggested Schedule of Professional Fees to determine reasonable fees for this service.

Records: Optometrists and Opticians Working Together

Council, Jan. 2017

Purpose

The College of Optometrists of Ontario and the College of Opticians of Ontario have developed this joint document to assist optometrists and opticians who work together. It explains the record keeping and record transfer obligations of each professional.

Record Keeping

An optometrist engaged in the practice of optometry in an optical store or with an optician or with a corporation, must do so as an independent contractor, which means that he or she is self-employed. Ontario Regulation 119/94 requires that an independent contractor optometrist must have a written agreement with the optical store, optician or corporation that states that the optometrist is the Health Information Custodian[8] and must control the maintenance, custody, and access to optometric patient records.[9]

An optician is required to produce opticianry patient records that must be maintained separately from optometric records.[10] Either the optician or the optometrist may be the Health Information Custodian of opticianry patient records. This is true both where the optician is an independent contractor and where the optician is an employee. Practitioners are strongly encouraged to enter into a written agreement about the custody of opticianry records. An agreement should state that the optician is able to access the opticianry records for regulatory purposes, including complaints and quality assurance. A written

[8] A Health Information Custodian is responsible for collecting, using and disclosing personal health information on behalf of patients. The *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Sched. A. sets out the rules for the collection, use and disclosure of health information and the responsibilities of the Health Information Custodian. Visit the website of the Office of the Information and Privacy Commissioner of Ontario to learn more: www.ipc.on.ca.

[9] O. Reg. 119/94 Part II Conflict of Interest paragraph 4. (5)(e) under the *Optometry Act*.

[10] See College of Opticians **Standards of Practice**, Standard 3

agreement regarding custody is also recommended where more than two practitioners work together in a joint practice.

When an Optometrist Leaves a Practice

When an optometrist closes his/her office or retires from practice, he/she must make arrangements to transfer a patient's records to,

- the patient;
- another optometrist, if the patient so requests; or
- another optometrist, with notice to the patient that his/her optometric patient records have been transferred to that optometrist [11]

Accordingly, when the agreement between an optometrist working as an independent contractor with an optician, optical store or corporation, is terminated, it is as if he/she closed an office. The optometrist cannot abandon the patient health records, nor leave them with the optical store, optician or corporation. The independent contractor optometrist must do one of the following:

- relocate his/her optometric patient records to another practice location, under his/her continued custodianship and with notice to patients of the new location of their records; or
- transfer optometric patient records to another optometrist, with notice to patients of the transfer[12].

When an optometrist either relocates his/her patient records to another practice location under his/her continued custodianship or transfers patient records to another optometrist at the same or a different practice location, the optometrist must provide notice to patients of the location and identity of the ongoing optometrist custodian of their records.

When an Optician Leaves a Practice

When an independent contractor optician closes his/her office or retires from practice, he/she must make arrangements to transfer a patient's records to:

- the patient;
- another optician, optometrist, or medical doctor, if the patient so requests or with notice to the patient;
- another person or entity that is a health information custodian, with notice to the patient; or
- the Archives of Ontario (or other archives, in certain circumstances).

The optician must make reasonable efforts to give notice to the patient before transferring the records to another health information custodian. If that is not

[11] O. Reg. 119/94 Part I Professional Misconduct paragraph 27 under the *Optometry Act*.
[12] OPR 5.1 The Patient Record under Professional Standards

reasonably possible, the optician must give notice as soon as possible after transferring the records.[13]

Cooperation Between Practitioners

Optometrists and Opticians who work together must cooperate to ensure that both are able to meet their regulatory responsibilities.
Interference by an optometrist or optician with another practitioner's record keeping duties may result in a finding of professional misconduct.

Self-regulation and Social Responsibility

Bulletin, Fall 2009

Most practitioners would agree that every person has a right to adequate health care regardless of their economic, social, or legal status. That said, the provision of health care is also a business. How is an optometrist to resolve the tension between the economics of practice and the desire to serve the public good? What is the responsibility of an optometrist to provide care to a disadvantaged member of the public?

Under self-regulation, optometrists are in the privileged position of having been delegated the authority to regulate their own profession. There are obligations that go along with this power. Self-regulation works because there is an understanding that professionals will apply their specialized knowledge and skill in the public interest. There is an agreement between the professions and the public they serve that in return for the privilege of self-governance, the profession has a duty to attend to the welfare of everyone, not just those who are socioeconomically advantaged.

The first principle listed on the Ethical Guide developed by the Ontario Association of Optometrists is:

> *Treat all patients with respect. Consider first their visual well being and provide appropriate care for all your patients. Do not exploit for personal advantage; nor discriminate against any patient.*

Discrimination can take many forms, including the level of access an individual is given to a practitioner's services, or whether an individual is accepted as a patient at all. An optometrist is not required to accept every person who walks through the door as a patient, but you must be sure that your reasons for not

[13] *Personal Health Information Protection Act, 2004,* section 42.

accepting a patient, or for limiting a patient's access to your services, are not rooted in your own personal financial interest.

Optometrists must abide by the Human Rights Code which prohibits discrimination on the following grounds: race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status, and disability. Failure to abide by the Human Rights Code may result in a proceeding before the Ontario Human Rights Tribunal. It could also result in disciplinary action by the College.
Paragraph **1.** (1) 53. of the Professional Misconduct Regulation states that it is professional misconduct to engage in conduct or perform an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

An ethical and transparent approach to economic issues will result in fair transactions. An optometrist's policies related to accepting patients, booking patients and fees for professional services are legitimate as long as professional ideals are upheld and just principles are followed.

An optometric practice operates as a business and if the business isn't sound, no one benefits. A balance between social and fiscal responsibility is essential. The key is in appreciating that you can earn a good living while cultivating a good social conscience.

Guidelines for the Appropriate Use of Social Media by Optometrists

With the advent of social media, optometrists have many new means of communicating with their patients and the public. There are many examples of social media platforms: Facebook, Twitter, YouTube, Linkedin, blogging sites, etc.

The nature of social media presents some risks for optometrists and patients alike. To manage these risks, when optometrists engage in the use of social media platforms and technologies, they are expected to adhere to all of their existing professional expectations and duties, including those set out in the relevant legislation, regulations, codes of ethics, and College policies. The College recognizes that if optometrists adhere to relevant professional expectations when engaging in social media, these platforms also present important opportunities to enhance education, professional competence, and collegiality and can also be an enjoyable source of information and entertainment.

Optometrists should keep in mind the principles of good optometric practice, which are also relevant to the use of social media. Optometrists have a responsibility to:

- safeguard patient privacy, confidentiality and trust by protecting patient information
- maintain appropriate professional boundaries between themselves and their patients
- maintain professional and collegial relationships with colleagues, other professionals, and in the public sphere
- collaborate with other health care professionals for the purpose of information exchange
- avoid conflicts of interest.

In order to satisfy the professional expectations while engaging in social media, optometrists are advised to:

- assume all content on the internet (anonymous or not) is public and accessible to all
- remember that social media platforms are constantly evolving
- refrain from invading the privacy of patients by seeking out information about them that may be available online
- refrain from posting identifying information about patients in any context online; for example, in a professional blog, video-sharing media, or discussion forum
- abide by statutes and regulations related to defamation, copyright and plagiarism when posting content in blogs or elsewhere online
- apply the strictest privacy settings to protect their own information and information about them that could be posted by others
- be mindful of their internet presence and be proactive in controlling and avoiding content which may be viewed as unprofessional or personal
- avoid providing patient specific optometric advice online, for example, by posting information on an internet discussion forum that could be construed as optometric advice. In some circumstances, it may be appropriate for optometrists to provide health-related information that is not patient-specific in an online forum for the purpose of public and professional education
- Proactively consider how other professional expectations apply to the use of social media.

Special Needs Accommodation

During the registration process, accommodation requests by applicants with special needs are handled on a case-by-case. Accommodation requests associated with a process or exam that is administered by a third party provider must be referred to the third party provider that administers the process or exam. For example, if it relates to challenging the evaluating exam, the accommodation request must be referred to Touchstone Institute. For other aspects of the registration process, applicants with special needs are required to fully complete the Accommodation Request Form. Documentation from a health professional unrelated to the candidate needs to be submitted directly to the College by the health professional in order to verify the special needs circumstances and accommodation indicated on the form.

Depending on the accommodation request and the follow-up required, it may take up to three (3) weeks before the College provides a response.

Uninsured Services: Fees and Charges

Bulletin, Mar. 1997

From time to time, the College receives inquiries from patients with respect to the costs associated with the provision of uninsured services. In some instances, the inquiry is simply to confirm that some services previously provided by O.H.I.P. are no longer insured services. In other instances, the inquiry deals with an unexpected bill for services provided.

When a patient is informed only after the fact that there will be charges for services provided, there are often feelings of anger and frustration. Patients understandably feel that they have not been dealt with fairly by their optometrist and, in reality, they have not been treated fairly by their optometrist.

Optometric patients have the right to know in advance of any services to be performed, and what, if any, the fees will be for the services. The patient given this information may consent to having the service(s) performed or the patient may refuse the service(s). This sharing of information, and the patient's right to accept or reject the service(s), is part of the tenet of informed consent.

An effective way to ensure that the patient knows in advance that certain services to be performed are the patient's financial responsibility is direct verbal communication between the optometrist and your patient. This should occur at the start of the examination and during the examination if additional tests are required.

Patients both expect and appreciate the optometrist taking the necessary time to

discuss proposed clinical services and the fees for those services before the services are rendered. This type of communication allows the patient to be more directly involved in his or her own care. It allows the patient to know what tests are to be performed, and why they are performed. This dialogue improves the quality of the relationship between the optometrist and the patient.

It is good for the professional and the patient to have open and honest communication about the financial arrangements that exist between both parties.

Failure to provide a patient with advance information regarding any services to be provided, the nature and reason for those services, and the fees involved may be considered a matter of professional misconduct under O.Reg. 859/93, s.1.53, the *Optometry Act, 1991*.

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Schedule of Benefits

for Optometry Services (April 1, 2009)

Ministry of Health and Long-Term Care

SERVICES OF OPTOMETRY

PREAMBLE

[Commentary:

The Schedule of Benefits for Optometry Services identifies the maximum amounts prescribed as payable under the *Health Insurance Act* for insured services rendered to insured persons by optometrists.

Insured optometry services are limited to the services which are listed in this Schedule and are subject to the conditions and limitations set out. It is an offence under the *Provincial Offences Act* and the *Commitment to the Future of Medicare Act* for an optometrist or other person or entity to charge an amount for the provision of insured services rendered to an insured person that is more than the amount payable by the Ontario Health Insurance Plan.

Services listed in this Schedule will become uninsured if they are rendered in those circumstances set out in s. 24 of Regulation 552 under the *Health Insurance Act* (for example services rendered solely for the purpose of a refraction for ages 20-64, "third party" requests, missed appointments, etc) .]

DEFINITIONS OF INSURED SERVICES

In this Schedule, "assessment of the eye and vision system" includes the diagnosis, treatment and prevention of,

a. disorders of refraction;

b. sensory and oculomotor disorders and dysfunctions of the eye and vision system;

and

c. diseases prescribed under the *Optometry Act*.

Any service, item or expense that supports assists or is a necessary adjunct to an insured service described in this Schedule is deemed to be a common element of the insured service described in this Schedule.

All specific procedures and/or specific and common elements listed below as included or as required for the provision of an insured service must be provided unless the element cannot be provided because an impairment or disability of the patient renders provision of the element physically impossible or the amount payable for the service is reduced to zero.

All specific procedures and/or specific and common elements listed below as included or as required for the provision of an insured service must be rendered by:

a. an optometrist personally;

or

b. a delegate of the optometrist,

i. subject to the supervision of the optometrist;

and

ii. when the optometrist is physically present in the office or clinic in which the service is rendered.

SERVICES OF OPTOMETRY

All insured services include the skill, time, premises, equipment, supplies, and personnel used to perform the specific and common elements of the service. The elements that are common to all insured services include:

- Keeping and maintaining appropriate clinical and financial records for each patient.
- Obtaining consents, conferring with or providing advice, information or records to physicians and/or other professionals associated with the health of the patient.

The following services rendered by optometrists are prescribed as insured services:

Periodic Oculo-Visual Assessment:

V404 and V406

A periodic oculo-visual assessment is an assessment of the eye and vision system for patients age 19 or less or age 65 or more.

Specific Elements: The periodic oculo–visual assessment includes all procedures necessary to perform the assessment, including the performance of all the following elements:

1. relevant history (ocular medical history, past medical history, family history);
2. visual acuity examination;
3. ocular motility examination;
4. refraction and the provision of a written refractive prescription if required;
5. slit lamp examination of the anterior segment;
6. ophthalmoscopy by one or more of direct, binocular indirect ophthalmoscope (BIO), monocular indirect ophthalmoscope (MIO) or non contact fundus lens;
7. advice and/or instruction to the patient;

and, if required in accordance with generally accepted professional standards, any or all of the following elements:

1. tonometry;
2. visual field examination by confrontation field;
3. dilated fundus examination by one or more of direct, binocular indirect ophthalmoscope (BIO), monocular indirect ophthalmoscope (MIO) or non contact fundus lens;

This service is limited to one per patient per consecutive 12 month period regardless of whether the first claim is or has been submitted for the same service rendered by an optometrist or for the service rendered by a physician described as a “Periodic Oculo-Visual Assessment” in the Schedule of Benefits for Physicians Services. Periodic oculo-visual assessments in excess of this annual limit are not insured services.

[Commentary:
A service that is not an insured service may not be billed to OHIP.]

SERVICES OF OPTOMETRY

Oculo-Visual Minor Assessments:

V402

Oculo-visual minor assessment for patients aged 19 or less or age 65 or more:

An oculo-visual minor assessment is an assessment of the eye and vision system clinically required for the purpose of assessing or reassessing a single ocular condition (including an ocular condition that may cause refractive change).

Where a claim is submitted by an optometrist for an oculo-visual minor assessment (V402) rendered on the same day that a claim is submitted for a periodic oculo-visual assessment (V404 or V406) rendered by an optometrist, the amount payable for the oculo-visual minor assessment is reduced to zero.

Where a claim is submitted by an optometrist for more than one oculo-visual minor assessment (V402) rendered to the same patient on the same day, the amount payable for the second and subsequent such assessments is reduced to zero unless the condition for which the patient presents for the second or subsequent such assessment is different than the condition for which the patient presented for the initial or any other such assessment rendered on the same day.

V408

Oculo-visual minor assessment for patients age 20 to 64:

An oculo-visual minor assessment is a reassessment of the eye and vision system following an insured major eye examination.

Specific Elements: An oculo-visual minor assessment includes the performance of all the following elements:

1. a history of the presenting complaint;
2. an assessment of the eye and vision system;
3. advice and/or instruction to the patient;
4. any or all related required procedures required to satisfy generally accepted professional standards.

This service is insured only when all of the following conditions are met:

1. the patient is an insured person to whom an insured major eye examination (fee schedule code V409) was rendered within the 12 month period preceding the date of the oculo-visual minor assessment (“the preceding major eye examination”);
2. the service is therapeutically necessary;
3. the oculo-visual minor reassessment does not include the service of refraction;

   and

4.

a. In the case of a patient to whom the preceding major eye examination (fee schedule code V409) was rendered pursuant to a valid requisition, the oculo-visual minor assessment is with respect to the same condition for which the requisition was issued;

or

b.

i. In the case of a patient with diabetes mellitus, the oculo-visual minor assessment is with respect to one or more diabetes-related ocular conditions identified by a diabetes-related ocular condition diagnostic code;

or

ii. In the case of a patient with any of the conditions set out in the description of the insured major eye examination (fee schedule code V409), the oculo-visual minor assessment is with respect to one or more of those conditions diagnosed in the preceding major eye examination.

Where a claim is submitted by an optometrist for an oculo-visual minor assessment rendered to a patient on the same day that a claim is submitted for a major eye examination rendered by an optometrist to the same patient, the amount payable for the oculo-visual minor assessment is reduced to zero.

Where a claim is submitted by an optometrist for more than one oculo-visual minor assessment rendered to the same patient on the same day, the second and subsequent oculo-visual minor assessment rendered to that patient on the same day is not an insured service.

[Commentary:
A service that is not an insured service may not be billed to OHIP.]

SERVICES OF OPTOMETRY

Major Eye Examinations:

V409

A major eye examination is an assessment of the eye and vision system for patients age 20 to 64 who satisfy one or more of the following conditions

a. The patient has one of the following medical conditions: diabetes mellitus, glaucoma, cataract, retinal disease, amblyopia, visual field defects, corneal disease, strabismus, recurrent uveitis or optic pathway disease;

or

b. The patient provides the optometrist with a valid requisition from a physician or a registered nurse holding an extended certificate of registration [(RN (EC)]. The requisition is not valid following the end of the fiscal year (March 31) of the 5th year following the year upon which the requisition was completed.

Specific Elements:
The major eye examination includes all procedures necessary to perform the assessment, including, the performance of all the following elements:

1. relevant history (ocular medical history, past medical history, family history);
2. visual acuity examination;
3. ocular motility examination;
4. refraction and the provision of a written refractive prescription if required;
5. slit lamp examination of the anterior segment;
6. ophthalmoscopy by one or more of direct, binocular indirect ophthalmoscope (BIO), monocular indirect ophthalmoscope (MIO) or non contact fundus lens;
7. advice and/or instruction to the patient ;
8. a letter outlining the findings of the examination provided to the patient's physician or a registered nurse holding an extended certificate of registration [RN (EC)] upon his or her request.

and, if required in accordance with generally accepted professional standards, any or all of the following elements:

1. tonometry;
2. visual field examination by confrontation field;
3. dilated fundus examination by one or more of direct, binocular indirect ophthalmoscope (BIO), monocular indirect ophthalmoscope (MIO) or non contact fundus lens.

This service is limited to one per patient per consecutive 12 month period regardless of whether the first claim is or has been submitted for the same service rendered by an optometrist or for a service rendered by a physician described as a "Major Eye Examination" in the Schedule of Benefits for Physician Services. Major eye examinations in excess of this annual limit are not insured services.

SERVICES OF OPTOMETRY

If the claim submitted to OHIP for a major eye examination does not contain either:

a. the appropriate diagnostic code reflecting the requirements of paragraph 4(a)

or

b. for services requested by a physician or registered nurse holding an extended certificate of registration [RN (EC)] , the requesting physician's OHIP billing number or the requesting RN (EC) billing number,

the amount payable for the service is reduced to zero.

Automated Visual Fields Assessment:

V410

Automated visual field assessment, or automated perimetry, is an assessment of the eye and vision system for the purpose of mapping the patient's visual fields.

For patients age 19 or less or 65 or more, the service is insured when the automated visual field assessment is clinically necessary to determine the extent and sensitivity of a patient's visual fields.

For patients age 19 or less or 65 or more, a claim may be submitted by an optometrist for automated visual field assessment on the same day or a different day as a claim is submitted for a periodic oculo-visual assessment (V404, V406) or oculo-visual minor assessment (V402), when, in the clinical judgment of the optometrist, it is necessary to determine the extent and sensitivity of a patient's visual fields.

For patients age 20 to 64 the service is insured when, following a major eye examination (V409) or minor assessment (V408), the automated visual field assessment is clinically necessary to determine the extent and sensitivity of a patient's visual fields.

For patients age 20 to 64, a claim may be submitted by an optometrist for automated visual field assessment on the same day or a different day as a claim is submitted for a major eye examination (V409) or a minor assessment (V408) when, in the clinical judgment of the optometrist, it is necessary to determine the extent and sensitivity of a patient's visual fields and the assessment is required for the same condition under which the initial insured assessment was coded.

SERVICES OF OPTOMETRY

OPTOMETRY SCHEDULE OF BENEFITS

FEE CODE	FEE DESCRIPTION	FEE AMOUNT
V402	Oculo-visual minor assessment for patients age 19 years or less or age 65 years or more	$25.15
V404	Periodic oculo-visual assessment for patients age 19 years or less	$42.50
V406	Periodic oculo-visual assessment for patients age 65 years or older	$47.00
V408	Oculo-visual minor assessment for patients age 20 to 64 years	$25.15
V409	Major eye examination for patients age 20 to 64 years	$43.80
V410	Automated Visual Field Assessment	$25.15

APPENDIX A

Appendix A does not form part of the Schedule of Benefits under the *Health Insurance Act* and is included in this publication for information purposes only.

MCSS PROGRAM

The services set out below are not "insured services" within the meaning of the *Health Insurance Act* but are paid by the Ministry of Health and Long-Term Care acting as paying agent on behalf of the Ministry of Community and Social Services (MCSS).

MCSS ONTARIO DISABILITY SUPPORT PROGRAM(ODSP)

V450 . . . . . $39.15

A periodic oculo-visual assessment rendered to patients between the ages of 20 and 64 who are recipients of income support under the *Ontario Disability Support Program Act*, 1997 to determine ocular health and identify refractive error, including all the procedures necessary to perform the assessment as set out in fee codes V404 and V406. This assessment is defined in the same manner and is subject to the same specific and common elements and requirements as a POVA insured under the *Health Insurance Act.*

MCSS ONTARIO WORKS PROGRAM (OW)

V451 . . . . . $39.15

A periodic oculo-visual assessment rendered to patients between the ages of 20 and 64 who are recipients of income assistance or benefits under the *Ontario Works Act,* 1997 to determine ocular health and identify refractive error, including all the procedures necessary to perform the assessment as set out in fee codes V404 and V406. This assessment is defined in the same manner and is subject to the same specific and common elements and requirements as a POVA insured under the *Health Insurance Act*.

> **Note:**
> These services are limited to one per patient per consecutive 24 month period regardless of whether the first claim for either service or a major eye exam is or has been submitted for a service rendered by an optometrist or physician. Services in excess of this limit are not covered.

This payment represents full payment for these services. No additional charge to either OHIP or the patient for this service is permitted.

All specific procedures and/or elements listed as required for the service must be personally performed by the optometrist claiming for the service provided or a delegate of the optometrist, subject to the supervision of the optometrist and provided that the optometrist is physically present in the office or clinic in which the service is rendered, or the service is payable at nil.

Ministry of Community and Social Services

Vision Care Fee Schedule

Intent

The Ontario Disability Support Program (ODSP) Vision Care Benefit provides assistance to eligible individuals with the purchase of optical goods and services from all eye care professionals.

Coverage of vision care benefits is limited to basic eyewear and replacements.

This schedule sets out allowable amounts for lenses and frames for those eligible for eyeglasses under ODSP Vision Care Benefit.

Payments will not exceed the amounts shown in the Ministry of Community and Social Services (MCSS) Vision Care Fee Schedule (see page 5 and 6).

If the cost of the lenses and/or frames exceeds the approved amount, the client is responsible for paying the difference in cost directly to the supplier. Any additional costs not covered by the schedule must be fully disclosed to, and accepted by, clients prior to the commencement of the service.

Who is Eligible

The benefits outlined in this Schedule are available to the following clients:

- ODSP recipients, their spouses and dependent children (0-17 years)
- Clients in receipt of the Extended Health Benefit, their spouses and dependent children (0-17 years)
- Persons eligible for the Transitional Health Benefit, their spouses and dependent children (0-17 years)
- Children receiving Assistance for Children with Severe Disabilities (ACSD)

<u>Who is not eligible for benefits outlined in this Schedule</u>

- Dependants of ODSP recipients 18 years and over other than the recipient's spouse. Note: Municipalities may provide coverage for ODSP dependent adults as a discretionary benefit.

Frequency and Limits

All eligible beneficiaries may receive new lenses and frames every 3 years, when necessary. (See below for further information)

Children may receive new lenses anytime there is a change in prescription.

Lenses

Basic single vision lenses will be plastic (either CR-39 or polycarbonate) with scratch resistant coating on both inner and outer surfaces.

Basic multifocal lenses will be plastic progressive addition lenses (either CR-39 or polycarbonate) with scratch resistant coating on both inner and outer surfaces.

Straight Top (ST) bifocal lenses will be available for eligible beneficiaries who have an established preference or special needs that require the use of ST bifocal lenses.

<u>High Index Lenses</u>

High index lenses are available for those with high refractive corrections (having a dioptric value of 8 dioptres of higher). High index lenses are available as single vision, bifocal or progressive addition lenses. High index lenses are to be ordered with the appropriate coatings (Scratch Resistant and Anti-Reflective).

See Appendix 1 – High Index Lenses for a list of high index lenses for the MCSS Vision Care Benefit.

Tints

Lens tints will only be covered when they are prescribed by an Optometrist or Ophthalmologist for medically necessary eye or vision conditions.

Frames

Frames are subject to the maximum amount as indicated in the schedule. A client may choose a more expensive frame and pay the difference in cost directly to the supplier.

Service providers may wish to request the funds from the client for upgraded frames in advance of delivering the service.

Replacement Lenses

<u>Replacement of Lenses Due to Change in Prescription</u>

Lens Replacements are not a standard benefit but rather based on need. If the replacement period has been achieved, there must still be evidence of a change in correction before replacement is covered.

If the replacement period has not been met, adults may receive new lenses only when there is a significant change in prescription. A significant change in prescription is defined as a change in refractive error of not less than 0.5 diopter to the sphere or cylinder power, or a change in axis equal to or greater than:

- 20 degrees for a cylinder power of 0.50 diopters or less;
- 10 degrees for a cylinder power of more than 0.50 diopters but not more than 1.0 diopter
- 5 degrees for a cylinder power of more than 1.0 diopter.

Children may receive new lenses anytime there is a change in prescription.

Prescribers are required to indicate, on the prescription, that a significant change in prescription has occurred when requests for new lenses are being made.

Note: The new lenses should be placed in existing frames if the existing frames are satisfactory. If the existing frames are not satisfactory, new frames may be provided.

Replacement of Frame Due to Loss or Damage

ODSP staff may authorize a replacement where a client has lost or damaged glasses through no fault of his/her own and they are not covered under warranty. There is no frequency limitation on authorized replacements for adults or children.

Unless the eyeglasses are lost, a client must present damaged frames to ODSP staff for confirmation and approval.

If a replacement is approved, the current lenses should be placed in the new frames if the existing lenses are satisfactory. If the existing lenses are not satisfactory, ODSP staff will authorize new lenses to be provided.

Exceptional Circumstances

A request for items outside the scope of the MCSS Vision Care Fee Schedule may be made where exceptional medical circumstances exist. Service providers must obtain pre-authorization from MCSS before providing Exceptional Circumstances services to clients.

Decisions on Exceptional Circumstances requests will be made by the Director of ODSP Branch. Decisions take into account recommendations of the Medical Advisory Unit (MAU) of the ODSP Branch.

The service provider must provide the following information:

- A copy of the Vision Care Authorization Form
- Completed Application - Vision Care Benefit (Exceptional Circumstances) form including:
    - Description of item/service being requested, and
    - Rationale for additional service, and
    - Cost of the item/service being requested.

Service providers must send their claim form to:

Ministry of Community and Social Services
Medical Advisory Unit
80 Grosvenor Street, 3rd Floor, Hepburn Block
Toronto, ON M7A 1E9

Clients should be advised that the service provider must obtain pre-authorization for items outside the schedule prior to providing the service.

MCSS will notify the service provider of the approval.

If there is not sufficient information provided to make an informed decision, a letter is sent to the service provider requesting additional information or explanation.

If a response if not received within 2 weeks of the request for additional information a follow-up call is made to the service provider.

Contact Lenses

If there is a situation where contact lenses are considered a medical necessity, written clinical rationale along with the glasses prescription are to be submitted to MAU. Medical necessity consists of the following conditions:

- corneal abnormalities
- astigmatism (only when it cannot be corrected by spectacle lenses)
- high refractive error where the error is greater than 8 diopters
- anisometropia

Vision Care Claim Form

Service providers should mail completed ODSP Vision Care Authorization/Invoice forms (Form 7730-1036) to the following address for processing:

Ministry of Community and Social Services
ODSP Vision Care Program
77 Wellesley Street West
Box 333
Toronto, ON M7A 1N3
416-212-9503

MCSS VISION CARE FEE SCHEDULE

ITEM	MCSS Maximum Amount Payable	Code
Lenses		
Single Vision		
Single Vision CR39 with Scratch Resistant Coating (both sides)	$68.50	001
Single Vision Polycarbonate with Scratch Resistance Coating	$76.50	002
Bifocal Lenses		
CR39 - Bifocals with Scratch Resistant Coating (both sides)	$94.50	003
Polycarbonate - Bifocals with Scratch Resistant Coating	$123.00	004
PALS/Trifocals Lenses		
CR39 - PALs with Scratch Resistant Coating (both sides)	$205.50	005
Polycarbonate PALs with Scratch Resistant Coating	$243.00	006
Trifocal CR-39 with Scratch Resistant Coating	$132.00	007
Trifocal Polycarbonate with Scratch Resistant Coating	$171.00	008
Additions		
High Sphere Power (10.00D - 16.00D) - additional cost	$39.75	009
High Cylinder Power (over 6.00D) - additional cost	$32.25	010
Prism (up to 10Δ) - additional cost	$27.50	011
High Reading addition (+4.25D to +6.00D) - additional cost	$60.00	012
Solid Lens Tints - additional cost	$21.50	013
Gradient Lens Tints - additional cost	$25.50	014
Photochromic Tints (Transitions, Colormatic etc) - additional cost	$105.00	015
Re-edging client's own lenses into a new frame	$20.00	016
Frame and Case		
Frame	$42.20	017
Case	$2.00	018

Appendix 1 - High Index Lenses

High Index Lenses

High index lenses are available for those with high refractive corrections (having a dioptric value of 8 dioptres of higher). High index lenses are to be ordered with the appropriate coatings (Scratch Resistant and Anti-Reflective).

High Index Lenses	MCSS Maximum Amount Payable	Code
Single Vision 1.67	$300.50	019
Bifocal 1.67	$388.50	020
PALS 1.67	$461.00	021

Updated MCSS Vision Care Fee Schedule

Questions and Answers for Service Providers

1. Why are these changes to the Vision Care schedule and Vision Care process being made?

There are a number of factors that have led the ministry to update and revise the schedule and process for vision care. The schedules are out of date and feedback received from Optometrists, Opticians, clients and caseworkers confirmed the need to update the schedules regarding services and products available.

The new fee schedule includes a basic range of lenses and frames that will meet the needs of most Ontario Disability Support Program (ODSP) clients.

Examples of improvements:

- Proposed schedules are simplified and updated.
- Obsolete items have been removed.
- The lenses outlined in the proposed schedule are considered a basic range of lenses.
- Streamlined and simplified to cover all spectacle necessities without brand names.
- All service providers are able to use the lens manufacturer of their choice.
- Price lists are no longer based on prescription powers. This simplifies the pricing and causes less error for claims.

Introduction of a new Exceptional Circumstances process will help ensure accountability and integrity of the Vision Care benefit.

2. When will the new schedule be implemented?

The new MCSS Vision Care Fee Schedule will go into effect on November 12, 2014.

3. Will clients be required to change their current Vision Care service providers?

Social assistance clients will not have to change service providers and will continue to have choice as to who provides vision care service to their family.

4. **Is there a new Vision Care form that caseworkers are required to provide to clients?**

   A new Vision Care Authorization Form, reflecting the new schedule, has been developed and will be available to recipients through their caseworker via the Social Assistance Management System (SAMS). This form is to be utilized as of November 12, 2014 and will be used in conjunction with the new schedule. The old Vision Care Authorization Form should not be issued to clients by caseworkers after November 10, 2014.

5. **A vendor already submitted an invoice before the implementation of the new schedule. Will these invoices/forms be processed?**

   Forms issued before November 10, 2014 will remain valid, as per normal standards, for 30-days after issuance. MCSS will assess and authorize all forms that abide by these standards.

   Old vision care claim forms issued after November 10, 2014, or not meeting the 30-day standard may be returned to the local office. Caseworkers will then be required to issue a new Vision Care form to the client.

6. **How many days does a client have to get their Vision Care Authorization Form completed by a service provider?**

   To avoid a lapse in the validity of the form, service should be provided within 30 days from the date the form is issued by the caseworker. As a reminder, forms are required to be completed and signed by the client's caseworker, the service provider and the client.

7. **Are service providers still required to provide "verification letters" along with the Vision Care Authorization Form for items not covered under the new schedule?**

   Service providers will no longer be required to provide "verification letters" for items not on the schedule. The "Special Circumstances" policy will be removed as the new schedule is expected to meet the needs of ODSP clients.

   An Exceptional Circumstances process will be in place for the updated schedule to ensure that clients receive medically necessary items that are not in the schedule.

8. Do service providers still need to request authorization letters from caseworkers for items/amounts not covered under the new schedule?

An Exceptional Circumstances process will be in place for the updated schedule to ensure that clients receive medically necessary items that are not in the schedule. Should a client require an item (e.g. contact lenses) that is not covered by the new schedule, the service provider will be required to submit an Exceptional Circumstances Request Form to the Medical Advisory Unit (MAU) at ODSP Branch.

Consequently, authorization letters will no longer be required for items not covered under the new schedule. The "Special Circumstances" policy will be removed as the new schedule has been updated and is expected to meet the needs of ODSP clients.

9. Are service providers expected to provide a copy of a client's prescription information to the client to provide to the caseworker?

Yes. Caseworkers are expected to keep a copy of the client's prescription information and file the information in the client's master file.

10. What happens when there is a request for new lenses due to a change in prescription before the replacement period has been met?

If a request for new lenses due to a change in prescription is made before the replacement period has been met, prescribers are required to indicate, on the prescription, that a significant change in prescription has occurred.

For adults, a significant change in prescription is defined as a change in refractive error of not less than 0.5 diopter to the sphere or cylinder power, or a change in axis equal to or greater than one of the following:

- 20 degrees for a cylinder power of 0.50 diopters or less;
- 10 degrees for a cylinder power of more than 0.50 diopters but not more than 1.0 diopter;
- 5 degrees for a cylinder power of more than 1.0 diopter.

Children may receive new lenses anytime there is a change in prescription.

The client should provide all relevant information to their caseworker before being issued the Vision Care Authorization Form.

11. Do service providers have to submit requests for contact lenses to the client's caseworker?

No. Requests for contact lenses are no longer submitted to the caseworker. If there is a situation where contact lenses are considered a medical necessity, a request for contact lenses may be covered under Exceptional Circumstance

process. Both the contact lens fitting fee and contact lens retail cost should be itemized on the Exceptional Circumstance form.

12. What is the Exceptional Circumstances process?

An Exceptional Circumstances process will be in place for the updated schedule to ensure that clients receive medically necessary items that are not in the schedule.

Decision-making under the Exception Circumstances process will be based on the recommendations of the Medical Advisory Unit who will consult with external vision care experts, as required. The ODSP Director will make the final decision on all exceptions requests.

A request for items outside the scope of the MCSS Vision Care Fee Schedule may be made where exceptional circumstances exist. Service providers must obtain pre-authorization from MCSS before providing Exceptional Circumstances services to recipients.

All Exceptional Circumstances requests are handled by the Medical Advisory Unit of the ODSP Branch.

The service provider must provide the following information:

- A copy of the Vision Care Authorization Form
- Completed Exceptional Circumstances Form including:
    - Description of item/service being requested, and
    - Rationale for additional service, and
    - Retail cost of the item/service being requested.

Service providers must send their claim form to:

Ministry of Community and Social Services
Medical Advisory Unit
80 Grosvenor Street, 3rd Floor, Hepburn Block
Toronto, ON M7A 1E9

Clients should be advised that the service provider must obtain pre-authorization for items outside the schedule prior to providing the service.

13. Where can I find the Exceptional Circumstances Form for the Vision Care Benefit?

The Exceptional Circumstances Form will be available on to service providers on the Ontario Shared Service web portal.

http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ACT=RDR&TAB=PROFILE&SRCH=&ENV=WWE&TIT=3183&NO=006-3183E

14. What is the Medical Advisory Unit (MAU), and what is their role?

The MAU is a unit within ODSP Branch. The MAU is responsible for reviewing and making recommendations on exceptional circumstances requests.

15. What is the timeframe for exceptional circumstance claims to be reviewed at the MAU?

The MAU will aim to review exceptional circumstances and provide a response within 15 business days.

16. What if a client chooses pay more than $42.20 for frames?

Items that do not meet the criteria for the Exceptional Circumstances process and are not listed on the Schedule are the responsibility of the client.

The schedule provides a frame allowance of $42.20. If the cost of the frames chosen by the client exceeds the amount in the schedule, the client is responsible for paying the difference in cost directly to the supplier.

If a client chooses a high index lens but does not meet the criteria listed in the Schedule (i.e. refractive error is less than +/- 8 diopters), the client is responsible for the difference in cost between the high index cost and the applicable insured lens cost (i.e. CR39 or polycarbonate lens).

Service Provider must advise the client that they would have to pay the difference.

17. What is the policy pertaining to replacement of frames due to loss or damage?

If a replacement is approved, the current lenses should be placed in the new frames if the existing lenses are satisfactory. If the existing lenses are not satisfactory, or if it is impractical to re-edge the lenses into new frames, new lenses will be authorized. The vision care provider is the party responsible for determining whether the existing lenses are satisfactory for re-edging.

18. Will the ODSP Vision Care Directive and Provincial Business Process be updated to reflect these changes?

Both the Directive and Business Process related to Vision Care will be updated.

19. With the new process, are clients required to pay for vision care services upfront?

In general, clients should be reminded that the ministry will cover certain costs related to vision care (as out lined in ODSP Policy Directive 9.14 and the MCSS Vision Care Fee Schedule) and that these cost will be paid directly to the vision care provider.

Clients may pay for items not listed in the schedule. Any additional costs not covered by the schedule must be fully disclosed to, and accepted by, the client prior to the commencement of the service.

Service providers may wish to request the funds for the additional costs not covered by the schedule from the client in advance of delivering the service.

20. Will a client be reimbursed by the ministry if they pay the provider for services that otherwise would have been covered by MCSS?

No. MCSS can only make payments to optometrists and opticians. Optometrists or opticians are not allowed to directly bill ODSP recipients if the services provided to the client are included in the MCSS Vision Care Fee Schedule.

The MCSS cannot pay clients directly, even if the services provided are covered or authorized by the ministry.

Should the MCSS become aware of a case where the client has paid the vendor directly and is now seeking reimbursement, the local office will be notified and the client will be advised to contact their caseworker.

21. Where do service providers submit invoices for payment?

There is no change in the payment of invoices. The ODSP Vision Care Program is responsible for processing payment for vision care service providers.

Invoices should be mailed to:

Ministry of Community and Social Services
ODSP Vision Care Program
77 Wellesley Street West
Box 333
Toronto, ON M7A 1N3

The ODSP Vision Care Unit will not evaluate exceptions or make decisions around exceptions.

The ODSP Vision Care Program can only process completed invoices. An invoice will be sent back to the service provider if is not completed, which will delay payment processing.

22. When can a Vision Care provider expect payment?

Payments are processed by the ODSP Vision Care Program. The ODSP Vision Care Program will aim to process the invoice within 30 days of receiving the completed form.

23. To ensure timely processing of payment, what documents must be received at the ODSP Vision Care Program?

The service provider must provide the following information:

- A copy of a completed Vision Care Authorization form
- Copy of the prescription

For invoices that include exceptions:

- A copy of a completed Vision Care Authorization form
- Copy of the prescription
- ODSP Director Approved Exceptional Circumstances form including:
    - Description of item/service being requested, and
    - Rationale for additional service, and
    - Cost of the item/service being requested.

To avoid delay the Vision Care Program suggests the following;

- Ensure the form is for ODSP and not Ontario Works
- All contact information is included on the form and legible
- Do not send in voided or expired forms

24. How can a Vision Care provider sign-up for Electronic Funds Transfer (EFT)?

To sign-up for Electronic Funds Transfer, vision care providers should contact the Ontario Shared Services contact centre at 416-212-2345 or toll free at 1-866-320-1756 or https://www.doingbusiness.mgs.gov.on.ca/mbs/psb/psb.nsf/EN/directdeposit .

25. Who should a vision care provider contact if they have a question regarding the processing of a specific payment?

For questions regarding payments ODSP Vision Care Program contacts:

Ministry of Community and Social Services
ODSP Vision Care Program

77 Wellesley Street West
Box 333
Toronto, ON M7A 1N3
SASI-Visioncare@ontario.ca
Fax: (647) 723-0343

26. Who should a vision care provider contact if a client refuses completed eyewear or does not pick up the eyewear?

The provider should contact:

Ministry of Community and Social Services
ODSP Vision Care Program
77 Wellesley Street West
Box 333
Toronto, ON M7A 1N3
SASI-Visioncare@ontario.ca
Fax: (647) 723-0343

27. How can suppliers locate their supplier number?

The MCSS Vision Care Program asks that suppliers include their Supplier Number on the ODSP Vision Care Authorization/Invoice forms. The Supplier Number is a unique identifier that helps ensure payments to suppliers are properly directed.

The Supplier Number is on all cheque stubs or Electronic Fund Transfer (EFT) statements on payments issued by the Ministry.

OPR

OPTOMETRIC PRACTICE REFERENCE

STANDARDS OF PRACTICE

COLLEGE OF Optometrists OF ONTARIO

The best eye health and vision for everyone in Ontario, through excellence in optometric care.

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PART 1. The Fundamentals

1. Introduction and Purpose

1.1 Introduction

The College of Optometrists of Ontario is the regulatory body for the optometric profession in Ontario. In order to assist the College in meeting its objects, documents relating to optometric practice are periodically developed and published. This Optometric Practice Reference (OPR) represents a complete revision of The Guide to the Practice of Optometry and supersedes previous versions of The Guide. It will be periodically updated in response to changes in public need, economic forces, advances in health care sciences, and statutory and regulatory requirements.

1.2 The Purpose of the OPR

The OPR fulfills three key functions, as follows:

- **To provide information to the public and patients** and/or their representatives regarding the services and behaviour that can be expected from a member of the College.
- **To inform members of the College** of the principles and criteria which underlie the standards of practice and behaviour of the profession.
- **To assist committees of the College** to carry out their work. Some statutory committees of the College are required to assess the practice of members in the course of fulfilling their mandate to protect the public. The principles, standards, and guidelines described herein serve as a basis for their assessment. The Quality Assurance Committee employs regulatory and professional standards when assessing the practice of individual members and uses the clinical guidelines to help members move towards best practices. The Complaints and Executive Committees consider standards and guidelines for the purpose of case disposition. An alleged breach of a regulatory or professional standard is usually required before a member will be referred to either the Quality Assurance or Discipline Committee.

2. The Practice of Optometry

2.1 Scope of Practice

The *Optometry Act* specifies the scope of practice of optometry as follows:

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

a) disorders of refraction;

b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and

c) prescribed diseases.

2.2 Authorized Acts

The Province of Ontario uses the concept of *controlled acts* to describe healthcare procedures and responsibilities that are not within the domain of the public. This forms the basis for regulation of healthcare services in the province. Fourteen of these *acts* are described in the *Regulated Health Professions Act* and each profession-specific act, such as the *Optometry Act*, specifies those that are authorized to the professional group.

In the course of engaging in the practice of optometry, optometrists are authorized, subject to the terms, conditions and limitations imposed on their certificate of registration, to perform the following:

1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.

2. Applying a prescribed form of energy.

2.1 Prescribing drugs designated in the regulations.

3. Prescribing or dispensing for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

2.3 The Practice of Optometry

There are several key principles that form the foundation for the optometric profession. The practice of optometry is:

Professionally based

Above all, the purpose of the optometric profession is to provide for the healthcare needs of patients, by placing the patient's best interest foremost.

Scientifically based

The profession of optometry is founded on research and education in the life and vision sciences, combined with scientific and technological expertise.

The College supports the use of evidenced-based techniques, instrumentation and therapies that have the support of peer-reviewed literature.

Primary health care

Optometrists are independent practitioners who work within Ontario's healthcare system in co-operation with other providers of related services for the ultimate benefit of patients.

Related to eyes and vision

The services generally provided in primary care optometry include:

- the assessment, diagnosis, management and prevention of conditions of the eye and vision system;
- the treatment, correction or rehabilitation of conditions of the eye and vision system;
- the dispensing of eye glasses, contact lenses, and low vision devices;
- referral to, or shared care with, allied health professionals; and
- the promotion of good vision and health through education.

Accountable to the public

The practice of optometry in Ontario is governed by the College of Optometrists of Ontario under the authority of the Regulated Health Professions Act and the Optometry Act. Accountability is assured in a number of ways including public representation on Council and College committees, and open (public) Council meetings and Discipline hearings. In addition, the College publishes an Annual Report and provides annual reports to the Minister of Health and Long-Term Care.

2.4 The Practitioner/Patient Relationship

With reference to the practitioner/patient relationship, the optometrist will:

Be accountable

Optometrists are accountable to their individual patients and to the College for all services provided, both personally and by others who are under their direction and supervision.

Act in the patient's best interest

Optometrists are responsible for fostering a relationship of trust with the patient and putting the patient's interest above their own. The Professional Misconduct

Regulations protect such interests. Examples of acts that are considered to be professional misconduct include:

- treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence; **(O.Reg. 119.94 Part I under the Optometry Act (1. s.10))**
- failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination. **(O. Reg. 119/94 Part I under the Optometry Act (1. s.11))**

Encourage patient decision-making

Consistent with patient-centered care, optometrists give patients the information and counselling necessary for them to make informed choices about treatment and ongoing care, and respect the choices their patients make.

When employing techniques, instrumentation and/or therapies that lack the support of peer-reviewed literature, optometrists are expected to discuss the risks and benefits with the patient and obtain informed consent with documentation where appropriate.

Protect confidentiality

Historical and clinical information is gathered in a manner respecting patient privacy. All records are kept confidential and secure. Release of information requires the consent of the patient or their representative(s), except as required or allowed by law, such as the *Personal Health Information Protection Act*.

Be ethical

Optometrists' behaviour and business practices conform to the profession's accepted ethical standards. This is emphasized in the Professional Misconduct Regulation which includes the following as an act of professional misconduct:

- engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical. **(O. Reg. 119/94 Part I under the Optometry Act (1. s.39))**

Effective Date: April 2014

Revised: September 2014

3. Standards: Definitions

The Optometric Practice Reference contains **standards of practice** (both regulatory and professional).

3.1 Regulatory Standards

Regulatory standards are found in the legislation of the Province of Ontario, such as the *Regulated Health Professions Act*, the *Ontario Regulations*, and the *Optometry Act*. These standards are mandatory requirements for the profession, and **must** be complied with by the optometrist. Non-compliance with these standards could result in an allegation of professional misconduct.

3.2 Professional Standards

Professional standards describe what a *consensus of prudent practitioners would do in certain circumstances.* Every profession has standards of practice that come from a variety of sources such as educational programs, clinical training, evidence-based literature, informal professional dialogue, and the decisions of a College and the Courts. In addition to writing standards into a regulation, a College may also publish documents that describe the existing generally accepted standards on recurring and /or significant issues. These publications are more valuable if they are the result of a consultation process.

The requirement to maintain the standards of practice is supported by the Professional Misconduct Regulation under the Optometry Act. While the strongest evidence of professional standards of practice is usually expert testimony, College publications and evidence based literature may support or reinforce the expert testimony and make it more likely to be accepted.

Revised: April 2014

PART 2. Optometric Care

4. General Clinical Matters

4.1 Clinical Equipment

Description

Optometrists are expected to be equipped with the instrumentation and supplies required to provide services that meet the standards of practice of the profession.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists have access to, and ensure proficient use of equipment, instrumentation, drugs and supplies for the following:

- measurement of visual acuity at distance and near;
- evaluation of visual fields and colour vision;
- determination of refractive status of the eyes, both objectively and subjectively;
- measurement of corneal curvature and thickness;
- assessment of ocular motility and binocular function;
- examination of the eye and ocular adnexa
- measurement of intraocular pressure;
- pupillary dilation, cycloplegia, topical ocular anesthesia, staining ocular tissues;
- measurement of the parameters of spectacles and contact lenses;
- in-office treatment of common primary ocular emergencies;
- disinfection of instruments and diagnostic contact lenses;
- infection control and cleanliness **(OPR 4.7)**.

When optometrists do not have a specific instrument, they must have arrangements in place whereby the tests may be performed elsewhere, by requisition or referral, and the results obtained for analysis and retention in the clinical record.

Optometrists are expected to maintain their equipment and instrumentation in good working order, including the provision of regular re-calibration.

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February 2015

November 2018

4.2 Required Clinical Information

The provision of optometric care relies on acquiring, updating and maintaining a complement of information about each patient. Analysis of these data enables optometrists to develop an accurate understanding of the ocular status of patients and devise appropriate management plans. Standards relating to required clinical information are intended to ensure the provision of optimal and efficient patient care.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Required clinical information to be obtained about patients at their first presentation includes:

- the chief concern or request(s);
- a review of ocular or visual symptoms or experiences;
- a general health history, with emphasis on eyes and vision, including medications used and applicable family history;
- the occupational and avocational visual environment and demands;
- the measurement and description of their ophthalmic appliances including purpose and effectiveness; and
- the results of the observation, examination or measurement of:
    - apparent and relevant physical, emotional and mental status;
    - the external eye and adnexa;
    - pupillary function;
    - the *anterior segment* **(OPR 6.1)** and, when indicated, corneal thickness;
    - ocular media;
    - the *posterior segment* **(OPR 6.2);**
    - intraocular pressure in adults and, when indicated, in children;
    - presenting monocular visual acuities at distance;

- presenting visual acuity at near, monocularly when clinically indicated;
- refractive status and best-corrected monocular visual acuity at distance;
- accommodative function, when clinically indicated and for school-age children;
- oculomotor status and, when indicated, fusional reserves;
- other sensory functions, when indicated, such as visual fields, colour vision, stereoacuity, sensory fusion and contrast sensitivity.

All required clinical information must be clearly documented in the *patient's health record* **(OPR 5.1)**. In situations where it is not possible to obtain specific required information, justification must be documented.

The information will be kept current by re-evaluation at subsequent examinations. Patient signs, symptoms and risk factors influence decisions optometrists make about the frequency of re-evaluation.

In emergency or urgent situations, it may be impractical to obtain all information at the first visit. In such cases, a specific assessment is appropriate **(OPR 4.6)**. Also, the full complement of required clinical information may not be necessary when providing specific assessments or consultation services for referring optometrists, physicians or nurse practitioners. The same applies to patients who have not been directly referred but are already under the established care of another optometrist or ophthalmologist. In such cases, optometrists will determine what is clinically necessary based on the reason for presentation.

Optometrists completing third party reports involving the clinical information of patients (e.g. MTO, CNIB, employment application reports), must verify the identity of patients using government issued photo identification cards.

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April 2014
June 2014
January 2018
June 2018
April 2020

4.3 Delegation and Assignment

Introduction

The Province of Ontario utilizes the concept of "controlled acts" to control who may perform healthcare procedures and responsibilities that have a high risk of harm associated with their performance. The controlled acts are listed in the Regulated Health Professions Act, 1991 (RHPA). Each profession-specific act, such as the Optometry Act, 1991, specifies any controlled acts that the members of the profession are authorized to perform (the profession's "authorized acts"). Each regulated profession has a defined scope of practice and some have corresponding authorized acts set out in the profession-specific Act.

There are also numerous non-controlled procedures, some of which are limited to objective data collection and others, which carry a potential risk of harm to the patient. Although these procedures are in the public domain (i.e. they are NOT controlled acts), they may require specific training and skills.

The term delegation refers to the process whereby a regulated health professional (RHP), who has a controlled act within his/her scope of practice, orders another person who would not otherwise be authorized to do so to perform this act.

The term assignment refers to the process of an RHP assigning the performance of a non-controlled procedure to another person.

Both delegation and assignment of optometric procedures in appropriate circumstances may allow a more timely and efficient delivery of optometric care, making optimal use of time and personnel. In every instance of delegation and assignment, the primary consideration should be the best interests of the patient.

It is a general expectation that optometrists will be responsible for, and appropriately supervise all delegated and assigned activities within their practices. The level of supervision varies with the risk associated with the delegated or assigned procedure. ***Direct supervision*** refers to situations in which the optometrist is physically present in the same clinical location. This allows the optometrist to immediately intervene when necessary. Direct supervision is expected for ALL delegation (controlled acts), and of any assigned activities, which require interpretation in the performance of the procedure and/or may present a risk of harm to the patient. ***Remote supervision*** refers to situations in which the presence of the optometrist is not necessarily required since there is no potential risk of harm to the patient. This would be appropriate for certain clinical procedures and objective data collection.

The responsibility for all aspects of any delegated acts or assigned procedures always remains with the optometrist.

Optometrists may also *receive delegation* of a controlled act not authorized to optometry.

Collaboration with other health professionals

Collaboration with other health professionals is a common occurrence in clinical practice. When an optometrist collaborates with another health professional, the College standards and guidelines on *collaboration* **(OPR 4.8)** will apply.

Regulatory Standards

Controlled Acts

The *Regulated Health Professions Act* identifies 14 controlled acts that may only be performed by members of certain regulated health professions:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

3. Setting or casting a fracture of a bone or a dislocation of a joint.

4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.

5. Administering a substance by injection or inhalation.

6. Putting an instrument, hand or finger,

i. beyond the external ear canal,

ii. beyond the point in the nasal passages where they normally narrow,

iii. beyond the larynx,

iv. beyond the opening of the urethra,

v. beyond the labia majora,

vi. beyond the anal verge, or

vii. into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.

8. Prescribing, dispensing, selling or compounding a drug as defined in the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.

9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.

11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.

12. Managing labour or conducting the delivery of a baby.

13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

Optometrists are authorized by the Optometry Act to perform 4 of the 14 controlled acts, as follows:

i. communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease;

ii. applying a prescribed form of energy;

iii. prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses; and

iv. prescribing a drug designated in the regulations.

The RHPA also discusses delegation of controlled acts:

27. (1) No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,

a. the person is a member authorized by a health profession Act to perform the controlled act; or

b. the performance of the controlled act has been delegated to the person by a member described in clause (a). 1991, c. 18, s. 27 (1); 1998, c. 18, Sched. G, s. 6.

28. (1) The delegation of a controlled act by a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

Exceptions

29. (1) An act by a person is not a contravention of subsection 27 (1) if it is done in the course of,

b. fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession.

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)**, includes the following acts of professional misconduct:

14. Failing to maintain the standards of practice of the profession.
15. Delegating a controlled act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
16. Performing a controlled act that the member is not authorized to perform.
17. Permitting, counselling or assisting a person who is under the supervision of a member to perform an act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regualtions under either of those Acts.
18. Permitting, counselling or assisting any person who is not a member to perform a controlled act which should be performed by a member.

Professional Standard

Delegation

Optometrist-Patient Relationship

Delegation will only occur after the optometrist has established a formal relationship with the patient, which normally will include an interview, an assessment, recommendations if appropriate, and informed consent about any clinical investigations and proposed therapy. In some cases where an established patient/practitioner relationship exists, delegation may take place before the optometrist sees the patient.

Presence of the Optometrist

Delegation of an authorized act must only take place when the optometrist is present in the same clinical location as the patient and is available to intervene when required.

Process for Delegation

The optometrist must establish a process for delegation that includes:

- education and assessment ensuring the currency of the delegate's knowledge, skills and judgement;
- documentation/references for performance of procedures; and
- ensuring the delegate has been delegated only those acts that form part of the optometrist's regular practice.

Informed Consent

Delegation occurs with the informed consent of the patient. Whether the consent is implicit or explicit will depend on the particular activity being proposed to be delegated.

Supervision

The optometrist supervises the delegated procedure by direct supervision.

Quality Assurance

The optometrist is expected to ensure there is an ongoing quality assurance mechanism.

Assignment

Optometrist-Patient Relationship

Assignment of certain procedures that are not controlled acts may occur as part of the optometric examination and may occur prior to the optometrist assessing the patient. For example, pre-testing using automated instruments may occur prior to the optometrist seeing the patient.

Presence of the Optometrist

Procedures that are completely objective, present no inherent risk of harm and require no interpretation by the person performing the procedure may be performed without the presence of the optometrist and are considered to be remotely supervised. This could include automated procedures such as objective auto-refraction, auto-perimetry and non-mydriatic retinal photography. However, the optometrist is expected to review the results of these remotely supervised procedures and communicate appropriately with the patient. Direct supervision must occur whenever the procedure poses an immediate (e.g. tonometry) or potential (e.g. subjective refraction) risk of harm.

Process for assignment

As with delegation, it is expected that assignment will only occur with certain processes in place, including:

- education and assessment ensuring the currency of the assignee's knowledge, skills and judgement;
- documentation/references for performance of procedures; and
- ensuring only those procedures that form part of the optometrist's regular practice are assigned.

Research Conducted by a University

An exception exists for delegation and assignment where medical direction is delegated with indirect supervision, with the informed consent of the subject, and where the research has received research ethics board approval from an accredited university.

Professional Standard for Receiving Delegation of Controlled Acts

In the public interest, there are situations when an optometrist could receive delegation from another regulated health professional (RHP) to perform a controlled act not authorized to optometry. Other RHP's have delegation regulations and established protocols for delegation of which the member should

be aware. In order for an optometrist to receive delegation from another RHP, all of the following criteria must be met:

i. a process for receiving delegation is in place;

ii. the member will have a reasonable belief that the RHP delegating the act is authorized to delegate the act, has the ability to perform the act competently, and is delegating in accordance with relevant regulations governing his or her profession;

iii. the optometrist should be competent to perform the act safely, effectively, and ethically;

iv. appropriate resources, such as equipment and supplies, are available and serviceable;

v. the delegated act is clearly defined;

vi. the duration of the delegation will be clearly defined and relate to a specific patient;

vii. the optometrist ensures that patient consent to having the act performed under delegation to the optometrist is obtained and recorded in the patient's health recordt;

viii. a mechanism exists to contact the RHP who delegated the act if there is an adverse or unexpected outcome; and

ix. the identity of the RHP delegating the controlled act and of the member

Last Reviewed: December 2018

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April 2014
January 2018
January 2019

4.4 The Use And Prescribing Of Drugs In Optometric Practice

Description

Optometrists use diagnostic and therapeutic drugs in the course of providing patient care. The College recognizes that there is a distinction between the use of drugs within a clinical setting and the prescribing of drugs for treatment. Optometrists with authority to prescribe drugs can do so to manage patients with diseases and disorders of the eye and vision system. Such drugs are usually topically applied eye drops or ointments and oral medications for corneal or eyelid infections only.

Regulatory Standard

The Optometry Act, 1991 states that in the course of engaging in the practice of optometry, optometrists are authorized, subject to terms, conditions and limitations imposed on his or her certificate of registration, to perform the following controlled act:

2.1 Prescribing drugs designated in the regulations.

The Designated Drugs and Standards of Practice Regulation, **(O.Reg. 112/11 under the Optometry Act, 1991)** describes the following conditions under which an optometrist may prescribe drugs and the drugs that may be prescribed:

Drugs that may be prescribed

1. For the purposes of paragraph 2.1 of section 4 of the Act, and subject to sections 2, 3 and 4 and Part II of this Regulation, a member may prescribe a drug set out under a category and sub-category heading in Schedule 1.

Limitation

2. Where a limitation or a route of administration is indicated in the sub-category heading set out in Schedule 1, a member shall only prescribe a drug listed under that subcategory in compliance with the limitation and in accordance with the route of administration specified.

Training required

3. No member may prescribe any drug unless he or she has successfully completed the relevant training in pharmacology that has been approved by the Council.

Recording

4. Every time a member prescribes a drug, the member shall record the following in the patient's health record as that record is required to be kept under section 10 of Ontario Regulation 119/94 (General) made under the Act:

1. Details of the prescription, including the drug prescribed, dosage and route of administration.

2. Details of the counselling provided by the member to or on behalf of the

patient respecting the use of the drug prescribed.

Non-prescription drugs

5. In the course of engaging in the practice of optometry a member may prescribe any drug that may lawfully be purchased or acquired without a prescription.

The standards of practice related to the prescribing of drugs for the treatment of glaucoma are as follows:

Prescribing of antiglaucoma agents

6. It is a standard of practice of the profession that in treating glaucoma a member may only prescribe a drug set out under the category of "Antiglaucoma Agents" in Schedule 1.

Open-angle glaucoma

7. (1) Subject to subsection (2) and to section 8, it is a standard of practice of the profession that a member may only treat a patient with glaucoma where the patient has primary open-angle glaucoma the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment.

(2) It is a standard of practice of the profession that a member may only treat a patient having open-angle glaucoma, the treatment of which is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment, in collaboration with a physician with whom the member has established a comanagement model of care for that patient and who is,

(a) certified by the Royal College of Physicians and Surgeons of Canada as a specialist in ophthalmology; or

(b) formally recognized in writing by the College of Physicians and Surgeons of Ontario as a specialist in ophthalmology.

Referral to physician or hospital

8. (1) Subject to subsections (2) and (3), it is a standard of practice of the profession that a member shall immediately refer a patient having a form of glaucoma other than primary open angle glaucoma to a physician or to a hospital.

(2) It is a standard of practice of the profession that a member may initiate treatment for a patient having angle-closure glaucoma only in an emergency and where no physician is available to treat the patient.

(3) It is a standard of practice of the profession that a member shall immediately refer any patient being treated in accordance with subsection (2) to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

(4) In this section, "hospital" means a hospital within the meaning of the Public Hospitals Act.

SCHEDULE 1

ANTI-INFECTIVE AGENTS

Antibacterials (topical)

azithromycin
besifloxacin
ciprofloxacin
erythromycin
framycetin
fusidic acid
gatifloxacin
gentamicin
moxifloxacin
ofloxacin
polymyxin B/gramicidin/neomycin
polymyxin B/neomycin/bacitracin
polymyxin B/trimethoprim
sulfacetamide
tetracycline
tobramycin

Antifungals (topical)

natamycin

Antivirals (topical)

trifluridine
Acyclovir

Antibacterials (oral) –

for corneal or eyelid infections only and for a duration not exceeding 14 days

amoxicillin
amoxicillin/clavulanic acid
azithromycin
cephalexin
ciprofloxacin
clarithromycin
clindamycin
cloxacillin
doxycycline
erythromycin
levofloxacin
minocycline
moxifloxacin

tetracycline

Antivirals (oral) – for corneal or eyelid infections only

acyclovir
famciclovir
valacyclovir

ANTI-INFLAMMATORY AGENTS

Corticosteroids (topical)

dexamethasone
difluprednate
fluorometholone
loteprednol
prednisolone
rimexolone

Corticosteroids (topical) - for the purpose of treating conditions of the eye and adnexa

triamcinolone

Immunomodulators (topical)

cyclosporine

Nonsteroidal anti-inflammatory agents (topical)

bromfenac
diclofenac
ketorolac
nepafenac

ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS

Antibacterials /corticosteroids (topical)

framycetin/gramicidin/dexamethasone
gentamicin/betamethasone
neomycin/fluorometholone
neomycin/polymyxin B/dexamethasone
neomycin/bacitracin/polymyxin B/hydrocortisone
sulfacetamide/prednisolone
tobramycin/dexamethasone

MYDRIATICS

Mydriatics (topical)

atropine
cyclopentolate
homatropine

tropicamide

ANTI-ALLERGIC AGENTS

Anti-allergic agents (topical)

bepotastine
emedastine
ketotifen
levocabastine
lodoxamide
nedocromil
olopatadine
tacrolimus – for the purpose of treating conditions of the eye and adnexa and for a duration not exceeding 42 days

ANTIGLAUCOMA AGENTS

ß-Adrenergic blocking agents (topical)

betaxolol
levobunolol
timolol

Carbonic anhydrase inhibitors (topical)

brinzolamide
dorzolamide

Miotics (topical)

carbachol
pilocarpine

Prostaglandin analogs (topical)

bimatoprost
latanoprost
tafluprost
travoprost

α-Adrenergic agonists (topical)

apraclonidine
brimonidine

α-Adrenergic agonists/ß-adrenergic blocking agents (topical)

brimonidine/timolol

Carbonic anhydrase inhibitors/ß-adrenergic blocking agents (topical)

brinzolamide/timolol
dorzolamide/timolol

Prostaglandin analogs/ß-adrenergic blocking agents (topical)

latanoprost/timolol

travoprost/timolol

Carbonic anhydrase inhibitors (oral) – to lower intraocular pressure only and a member shall immediately refer the patient to a physician or to a hospital

acetazolamide

SECRETAGOGUES

Secretagogues (oral) – for Sjögren's syndrome only and only in collaboration with a physician with whom the member has established a co-management model of care

pilocarpine

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The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.(3)

8. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists utilizing drugs within their practices for diagnostic and therapeutic purposes will:

- use only drugs for which they have been appropriately trained, establish a diagnosis and management plan based upon case history, clinical findings and accepted treatment modalities
- not dispense a drug

- document the drug(s) used, including concentration (when applicable) and dosage
- provide appropriate patient counselling including:
- general information, including management options, a description of the treatment(s), expected outcomes and normal healing course
- specific information including any potential significant risks and complications requiring *urgent or emergency care* **(OPR 4.6)**
    - how to access after-hours support and emergency care
    - arrange appropriate follow-up care as indicated
- refer the patient to an appropriate health care provider when clinically indicated

Prescribing of Drugs by Optometrists with Authority to Prescribe Drugs

In addition to the above conditions, those with authority to prescribe drugs:

- will maintain appropriate continuing education relevant to the treatment of eye disease by drug therapy as specified by the College
- may issue a *prescription* **(OPR 5.2)** and document the treatment and counselling in the *patient health record* **(OPR 5.1)**

Use of Drugs by Optometrists without Authority to Prescribe Drugs

Optometrists without authority to prescribe drugs have several options for the treatment of patients with conditions requiring drug therapy, such as:

- refer to another optometrist with authority to prescribe drugs;
- refer to another regulated health care provider who can provide such care appropriate to the condition;
- initiate office treatment, then, make a referral, as above, if required for the condition

It is professional misconduct if a prescription for drugs is issued by an optometrist without authority to prescribe drugs.

Last Reviewed: September 2017

First published: April 2004
(The Guideline for the Use of Drugs by Optometrists)

Revised: April 2011
(The Use and Prescribing of Drugs in Optometric Practice)

April 2014

February 2017

4.5 Referrals

Description

A referral is a request for consultation and/or the provision of treatment made to another regulated health professional when a patient requires care that exceeds the optometrist's scope of practice or ability.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient in determining the necessity of appropriate referral for care. Their decisions, about the urgency and choice of consultant are influenced by the ocular and/or systemic conditions and risk factors of patients, the community in which optometrists practise and the availability of appropriate consultation.

Once the decision has been made to make a referral, appropriate documentation in the patient's *health record* **(OPR 5.1)** is necessary, including:

- confirmation of when the referral was requested (e.g. fax information or written documentation of telephone conversation);
- appointment date, time, and consultant;
- confirmation with the patient of the appointment time and location; and
- a copy of the pertinent clinical information forwarded to the consultant.

Timeliness of Referral

Acute conditions that pose an immediate threat to the health and/or vision of the patient require a prompt referral. Examples of these conditions include, but are not limited to:

- acute glaucoma;
- retinal detachment;
- papilledema;
- central corneal ulcer;
- sudden, unexplained vision loss; or
- vision-threatening trauma.

If the patient is placed at risk because the referral appointment is not available within an appropriate amount of time, optometrists are required to advocate on their patient's behalf to attempt to arrange a more timely appointment. Otherwise, optometrists may need to seek an alternative source of care such as a hospital emergency department.

Last Reviewed: February 2018

First Published: January 2007

Revised: April 2014

September 2014

4.6 Ocular Urgencies and Emergencies

Description

Urgencies and emergencies represent potential threats to the ocular and/or systemic health and well being of patients if not dealt with appropriately. Accordingly, specific examinations are performed to provide prompt assistance, intervention, and/or action to limit potential sequelae.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

In urgent or emergency situations, any treatment initiated by optometrists will be within the profession's scope of practice **(OPR 2.1)**, and will not exceed their experience or competence. An exception to this would be if a controlled act has been delegated **(OPR 4.3)** by a member of another regulated health profession with that authority; optometrists receiving such delegation must be properly trained to do so. Generally, optometrists are expected to:

- establish appropriate protocols and ensure that staff members are trained to recognize and respond to urgent and emergency situations;
- conduct a specific examination to evaluate the immediate problem;
- counsel 'at-risk' patients about signs and symptoms that may require further care (for example, possible retinal detachment symptoms following a posterior vitreous detachment);
- counsel patients to whom they have prescribed drugs regarding potential adverse reactions, and when the need for emergency services may be required; and
- make themselves available for contact by patients to whom they have initiated treatment of an urgent condition.

If the treatment involves a *referral* **(OPR 4.5)** to another health professional, the timeliness of the appointment will be appropriate to the condition and remains the responsibility of optometrists even if a staff member makes the appointment.

Last Reviewed: September 2012

First Published: September 2007

Revised: May 2009

February 2013

April 2014

4.7 Infection Control in the Optometric Office

Description

Within all health care facilities there is a risk of transmission of infectious agents. Standards demand that all health care workers must mitigate that risk by being educated and proactive in the area of infection control. Documents and guidelines on the topic of infection control are published and periodically updated by government agencies, health care groups and academic institutions. All optometrists must be cognizant of current information on infection control and take appropriate measures within their practices.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

39. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

Professional Standard

Optometrists must take reasonable and appropriate measures to minimize the risk of contamination and subsequent transmission of infectious agents within their professional practices.

Last Reviewed: December 2016

First published: April 2011

Revised: February 2013

April 2014

4.8 Collaboration and Shared Care

Description

The term "collaboration" has arisen to describe sharing of care between professionals. Such shared care is usually complementary. It has become apparent that professionals who provide complementary health care services to patients often will find ways to work together to co-manage/share care of patients. This is often beneficial to patients as it may allow better accessibility to the health care system, lower costs to the system and patients and allow more specialized practitioners to devote more time to their area of expertise.

Optometrists collaborate with many health care professionals including other optometrists, ophthalmologists, family physicians, other medical practitioners, nurse practitioners and opticians. This document describes the characteristics and conditions of collaboration as they apply to the profession of optometry.

History

Optometrists have the regulatory obligation to refer patients to an appropriate regulated health professional (RHP) when the patient's condition and/or treatment is beyond the scope of practice of the optometrist. This has usually resulted in referral to family physicians or ophthalmologists to institute medical and/or surgical care. Various shared care relationships have developed in this regard including *glaucoma* management **(OPR 7.2)**, *cataract* surgery **(OPR 7.3)** and *refractive surgery* **(OPR 7.8).** Although these relationships are common, formal arrangements are usually not developed.

The Health Professions Regulatory Advisory Counsel (HPRAC) made recommendations in its New Directions report (2006) that optometrists and physicians develop formal collaborative relationships with opticians regarding the latter professional group providing refractive data to assist in the development of a *prescription* **(OPR 6.3)** for vision correction. HPRAC also recommended that optometrists and ophthalmologists develop collaborative relationships with regards to the management of *glaucoma* patients. **(OPR 7.2)**

Regulatory Standards

Controlled Acts

The *Regulated Health Professions Act* (RPHA) identifies 14 controlled acts that may only be performed by members of certain regulated health professions. Optometrists are authorized by the *Optometry Act* to perform 4 of the 14 controlled acts, as follows:

- communicating a diagnosis identifying as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease;
- applying a prescribed form of energy;
- prescribing or dispensing, for vision or eye problems, subnormal vision devices,

contact lenses or eye glasses; and

- prescribing a drug designated in the regulation.

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct: :

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

15. Delegating a controlled act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.

16. Performing a controlled act that the member is not authorized to perform.

17. Permitting, counselling or assisting a person who is under the supervision of a member to perform an act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.

18. Permitting, counselling or assisting any person who is not a member to perform a controlled act which should be performed by a member

Professional Standard

When an optometrist establishes a collaborative relationship with another RHP, that relationship must be in the best interests of the patient. A formal collaborative relationship will:

- have a verifiable agreement between collaborating professionals which outlines the various responsibilities, accountabilities and exchange of appropriate information for each person;
- ensure that patients fully understand the roles and responsibilities of the professionals involved and any associated fees;

- ensure that patients understand their options for care;
- have a mechanism for conflict resolution amongst all parties; and
- ensure the collaborating professionals adhere to any applicable standards of practice and conflict of interest regulations for each profession.

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September 2017

5. Documentation

5.1 The Patient Record

Description

The Patient Record is comprised of two essential parts: the Patient Health Record, including all clinical documentation, and the Financial Record, summarizing diagnostic and treatment fees charged to and paid by the patient. The record is a legal document, with a purpose of meeting professional regulatory requirements, and shall be available for use in the following College processes: Inquiries Complaints and Reports, Discipline and Quality Assurance.

Regulatory Standard

Optometrists shall take all reasonable steps necessary (including verification at reasonable intervals) to ensure that records in relation to their practice are kept in accordance with the regulations.

The regulations governing record keeping are contained in **O.Reg.119/94, Part IV, s. 7-12** as follows:

PART IV
RECORDS

7. (1) A member shall take all reasonable steps necessary to ensure that records in relation to his or her practice are kept in accordance with this Part. **O. Reg. 749/94, s. 3.**

(2) Reasonable steps under subsection (1) shall include the verification by the member, at reasonable intervals, that the records are kept in accordance with this Part. **O. Reg. 749/94, s. 3.**

8. Every member shall keep a daily appointment record that sets out the name of each patient whom the member examines or treats or to whom the member provides any service. **O. Reg. 749/94, s. 3.**

9. (1) Every member shall keep a financial record for each patient. **O. Reg. 749/94, s. 3.**

(2) The financial record must include the member's fees for services and any commercial laboratory costs charged to the member. **O. Reg. 749/94, s. 3.**

10. (1) Every member shall keep a patient health record for each patient. **O. Reg. 749/94, s. 3.**

(2) The patient health record must include the following:

1. The name and address of the patient and the name of the member who provided the service.

2. The date of each visit of the patient.

3. The name and address of any referring health professional.

4. The patient's health and oculo-visual history.

5. The clinical procedures used.

6. The clinical findings obtained.

7. The diagnosis, when possible.

8. Every order made by the member for examinations, tests, consultations or treatments to be performed by any other person.

9. Particulars of every referral to or from another health professional.

10. Information about every delegation of a controlled act within the meaning of subsection 27 (2) of the Regulated Health Professions Act, 1991, delegated by the member.

11. Information about a procedure that was commenced but not completed, including reasons for non-completion.

12. A copy of every written consent to treatment. **O. Reg. 749/94, s. 3.**

(3) Every part of a patient health record must be dated and have a reference identifying the patient or the patient health record. **O. Reg. 749/94, s. 3.**

(4) Every entry in the patient health record must be dated and the person who made the entry must be readily identifiable. **O. Reg. 749/94, s. 3.**

(5) Every patient health record shall be retained for at least 10 years following,

(a) the patient's last visit; or

(b) if the patient was less than 18 years old at the time of his or her last visit, the day the patient became or would have become 18 years old. **O. Reg. 749/94, s. 3.**

11. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

1. Allowing any person to examine a patient health record or giving a copy of a document or any information from a patient health record to any person except as required by law or as required or allowed by this section.

2. Failing to provide copies from a patient health record for which the member has primary responsibility, as required by this section. **O. Reg. 749/94, s. 3.**

(2) A member shall provide copies from a patient health record for which the member has primary responsibility to any of the following persons on request:

1. The patient.

2. A personal representative who is authorized by the patient to obtain copies from the record.

3. If the patient is dead, the patient's legal representative.

4. If the patient lacks capacity to give an authorization described in paragraph 2,

i. a committee of the patient appointed under the Mental Incompetency Act,

ii. a person to whom the patient is married,

iii. a person, with whom the patient is living in a conjugal relationship outside marriage, if the patient and the person,

A. have cohabited for at least one year,

B. are together the parents of a child, or

C. have together entered into a cohabitation agreement under section 53 of the Family Law Act,

iv. the patient's son or daughter,

v. the patient's parent. **O. Reg. 749/94, s. 3; O. Reg. 390/06, s. 1.**

(3) It is not an act of professional misconduct under paragraph 2 of subsection (1) for a member to refuse to provide copies from a patient health record until the member is paid a reasonable fee.

(4) A member may provide copies from a patient health record for which the member has primary responsibility to any person authorized by or on behalf of a person to whom the member is required to provide copies under subsection (2).

(5) A member may, for the purposes of providing health care, allow a health professional to examine the patient health record or give a health professional a copy of a document or any information from the record. **O. Reg. 749/94, s. 3.**

12. For record keeping required by this Part, a member may use computer, electronic or other equipment for recording, storing and retrieval of records if,

(a) the record keeping system provides ready access by an authorized investigator, inspector or assessor of the College, or the patient or the patient's representative to the records;

(b) ancillary equipment is readily available for the making of hard copies of the record at no expense to an authorized investigator, inspector or assessor of the College;

(c) the equipment or software being used is such that no amendment, correction, addition or deletion can be made to any record which obliterates the original record or does not show the date of the change. **O. Reg. 749/94, s. 3.**

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following act of professional misconduct:

27. If a member closes his or her office or retires from practice, failing to make reasonable efforts to make arrangements with a patient or his or her authorized representative to transfer the patient's records to,

i. the patient or his or her authorized representative,

ii. another member, if the patient or his or her authorized representative so requests, or

iii. another member, with notice to the patient that his or her records have been transferred to that other member.

Optometrists maintain the information contained within their records in trust, and in compliance with Ontario's Personal Health Information Protection Act (PHIPA).

Professional Standard

In addition to the regulatory requirements, the patient health record shall also:

- be legible and complete;
- be maintained in either English or French;
- include the date of birth;
- include proposal(s) for care and advice offered;
- include a description of the care rendered and recommendations for ongoing care;
- include details of all patient communication (both in person and electronic);
- be maintained to allow for easy identification and location of all documentation related to the provision of care;
- indicate deviations from usual care due to patient refusal or inability to cooperate; and
- make specific notation in the event that a test was performed or a question asked and the result was 'negative' or 'normal'.

Patient Access to Records

The right of patients to access the information in their record or direct that the information be transferred to another health care provider must not be limited in any manner, except as allowed by regulation. It is the right of patients to choose who provides care to them.

Relocation of a Patient Health Record

In situations where optometrists relocate their practice or entrust the custody of records to another optometrist in another location, optometrists entrusted with the maintenance of the records must make a reasonable attempt to inform patients of the location of the records.

Electronic Records

Members must produce complete financial records and patient health records (as defined by the regulation **(O. Reg. 119/94 Part IV, S.12)** upon request.

In addition to the regulatory requirements, optometrists are expected to utilize reasonable and reliable backup systems.

Where patient information is stored on mobile devices or offsite in an identifiable form, the information must be encrypted.

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June 2014

5.2 The Prescription

Description

A prescription is an order between an optometrist and a patient. A prescription is based upon the analysis of all available clinical information and subsequent diagnoses from optometric examination. Optometrists may issue two distinct types of prescriptions: **optical prescriptions,** which when combined with further appliance-specific information, enable the patient to obtain eyeglasses, contact lenses or subnormal vision devices; and **prescriptions for drugs,** which specify topical or oral drugs used to treat certain ocular diseases.

Regulatory Standard

The *Optometry Act, 1991(as amended 2007)* lists four authorized acts that can be performed by optometrists subject to the terms, conditions and limitations on their certificate of registration. Two of those acts are:

- Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eyeglasses. (1991, c. 35, s. 4".)
- Prescribing drugs designated in the regulations

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act, 1991)** includes the following acts of professional misconduct:

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes hve been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

The Designated Drugs and Standards of Practice Regulation, **(O.Reg. 112/11 under the Optometry Act)** describes the following conditions under which optometrists may prescribe drugs:

Drugs that may be prescribed

1. For the purposes of paragraph 2.1 of section 4 of the Act, and subject to sections 2, 3 and 4 and Part II of this Regulation, a member may prescribe a drug set out under a category and sub-category heading in Schedule 1.

Limitation

2. Where a limitation or a route of administration is indicated in the sub-category heading set out in Schedule 1, a member shall only prescribe a drug listed under that sub-category in compliance with the limitation and in accordance with the route of administration specified.

Training required

3. No member may prescribe any drug unless he or she has successfully completed the relevant training in pharmacology that has been approved by the Council.

Recording

4. Every time a member prescribes a drug the member shall record the following in the patient's health record as that record is required to be kept under section 10 of Ontario Regulation 119/94 (General) made under the Act:

1. Details of the prescription, including the drug prescribed, dosage and route of administration.
2. Details of the counselling provided by the member to or on behalf of the patient respecting the use of the drug prescribed.

Non-prescription drugs

5. In the course of engaging in the practice of optometry, a member may prescribe any drug that may lawfully be purchased or acquired without a prescription.

Professional Standard

Optometrists issue a prescription only after establishing a professional relationship with the patient, completing an appropriate examination and obtaining a full understanding of the relevant aspects of the patient's needs, ocular health, refractive status and/or binocular condition. The prescribed therapy must be within the scope of practice of the optometrist and in the patient's best interest. Optometrists are responsible to counsel their patients in the use of any prescribed therapy and required follow-up. The prescription and appropriate counselling must be documented in the patient record. In the event that a patient experiences an adverse or unexpected response to the prescribed therapy, optometrists will provide additional diagnostic and/or counselling services and, if required, make appropriate modifications to the management plan.

***All* prescriptions** must contain information that:

- Clearly identifies the prescribing optometrist, including name (with degree and profession), address, telephone number, license (registration) number and signature;
- Clearly specifies the identity of the patient; and
- Specifies the date prescribed.

If optometrists determine that a prescribed therapy is required, a prescription **must** be provided as part of the assessment without additional charge, regardless of whether the examination is an insured or uninsured service.

Patients have the right to fill their prescriptions at the dispensary or pharmacy of their choice.

A. Optical Prescription

An optical prescription must also:

- Contain information that is used by a regulated professional to dispense eyeglasses, contact lenses or a subnormal vision device that will provide the required vision correction **(OPR 6.3)** for the patient; and
- Specify an expiry date.

A spectacle prescription (prescription for eyeglasses) must be provided to the patient without request and without additional charge, regardless of whether the examination is an insured or uninsured service. Charges for additional copies of the prescription are at the discretion of the optometrist.

When optometrists have performed the necessary services to prescribe a specific appliance (e.g. contact lens), an appliance-specific prescription including the parameters of that appliance must be provided to the patient upon request. Optometrists may withhold this information pending payment for the related service.

B. Prescription for Drugs

A prescription for drugs must also contain:

- the drug name, dose, dose form;
- directions to the pharmacist such as quantity to be dispensed, refills allowed and an indication if **no** substitutions are permitted;
- directions to the patient; and
- the optometrist's **original** signature.

To provide timely care, it may be necessary to fax a prescription for drugs to a pharmacy. This fax must contain appropriate information verifying that it originates at the prescribing optometrist's office.

When it is necessary to verbally communicate a prescription for drugs to a pharmacy, the details must be fully documented in the patient record, including the name of the pharmacy and any staff members assisting in the calll.

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April 2015
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6. General Procedures

6.1 Anterior Segment Examination

Description

The anterior segment can be considered as the front third of the eye, encompassing the structures in front of (that is, anterior to) the vitreous humour, including, the lids and lashes, conjunctiva and sclera, cornea, anterior chamber, iris, and crystalline lens. The anterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders and dysfunctions of the eye and vision system. Information obtained from an anterior segment examination is part of the *required clinical information* **(OPR 4.2)**.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral..

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient in and equipped for examining the anterior segment. The equipment customarily used for the assessment is the slit-lamp biomicroscope.

A complete anterior segment examination must include an inspection of the following anatomical areas:

- lids, lashes and adnexa;
- conjunctiva and sclera;
- tear film;
- cornea, (and corneal thickness when indicated);
- anterior chamber and angle;
- iris; and
- crystalline lens.

All patients will receive an anterior segment examination as a part of initial and ongoing optometric care. Emphasis is given to the evaluation of the anterior chamber angle prior to pupillary dilation and in patients with diagnosed or suspected glaucoma. The optometrist's decision regarding the frequency and extent of the examination and the specific techniques utilized will be influenced by a patient's signs, symptoms and risk factors.

An anterior segment examination is an essential component of all *contact lens assessments* **(OPR 6.5)**.

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April 2014

6.2 Posterior Segment Examination

Description

The posterior segment can be considered as the back two-thirds of the eye, encompassing the structures posterior to the crystalline lens, including the vitreous humour, optic nerve head, retina and choroid. The posterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders, and dysfunctions of the eye and visual system. Information obtained from a posterior segment examination is part of the *required clinical information*. **(OPR 4.2)**.

Examination Procedures

METHOD	CHARACTERISTICS
1 Direct Ophthalmoscopy	Maximum magnification Minimum field of view
2 Binocular Indirect Ophthalmoscopy	Maximal field of view Minimal magnification Scleral indentation view Minimal range of condensing lens, fixed objective lens
3 Monocular Indirect Ophthalmoscopy	Moderate field of view Moderate magnification
4 Slit Lamp / Biomicroscopy (slit lamp photography)	High magnification and a very bright light source permit better appreciation of the optic nerve, macula, retinal vessels and other posterior pole structures.
5 Fundus Photography / Fundus Autofluorescence	Moderate to wide field of view and magnification with a wide range of filters and recording media. Colour, black and white, film or digital recording.
6 Imaging Technologies	Include, but are not limited to: • optical coherence tomography (OCT) • confocal scanning laser ophthalmoscopy (SLO) • scanning laser polarimetry (GDx) • multi-spectral imaging • macular pigment optical density (MPOD) measurement

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or

should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient, and *equipped* **(OPR 4.1)**, to examine the posterior segment.

A complete posterior segment examination must include an inspection of the following anatomical structures:

- vitreous humour
- optic nerve head
- macula and fovea
- retinal vasculature
- retinal grounds including, posterior pole, mid-periphery and where clinically indicated and/or possible, peripheral retina, and ora serrata.

All patients will receive a posterior segment examination as a part of initial and ongoing optometric care. An optometrist's decision about the frequency of examination, extent of view and methods of examination of the posterior segment, including the use of pharmacological pupillary dilation, will be influenced by a patient's signs, symptoms and risk factors.

Pharmacologic Dilation

Pharmacologic dilation **(OPR 4.4)** of the pupil is generally required for a thorough evaluation of the ocular media and posterior segment. Dilation can also facilitate examination of the anterior segment structures when certain conditions are present or suspected. The results of the initial dilated examination usually indicate the appropriate timing for subsequent pupillary dilation.

The following lists some of the situations/patient symptoms that indicate dilation is required (unless contraindicated) with the informed consent of the patient. These situations/patient symptoms include but are not limited to:

- symptoms of flashes of light (photopsia), onset of or a change in number or size of floaters;
- unexplained or sudden vision change, loss, or distortion (metamorphopsia);
- the use of medication that may affect ocular tissues (including but not limited to hydroxychloroquine, phenothiazine, long-term steroids);
- the presence of systemic disease that may affect ocular tissues (including but not limited to diabetes, hypertension);
- a history of significant ocular trauma, or ocular surgery that increases risk to the posterior segment;

- a history of moderate to high axial myopia;
- when a better appreciation of the fundus is required (including but not limited to choroidal nevus, optic nerve anomaly);
- when the ocular fundus is not clearly visible through an undilated pupil (including but not limited to cataract);
- when there is a known or suspected disease of:
  - the vitreous (including but not limited to vitreous hemorrhage);
  - the optic nerve (including but not limited to glaucoma);
  - the macula (including but not limited to age-related macular degeneration);
  - the peripheral retina (including but not limited to lattice degeneration);
  - the choroid (including but not limited to melanoma).

Optometrists choose the dilating agent after considering the extent of pupillary dilation desired, the patient's health history and clinical ocular characteristics, as well as the implications of expected side effects on the patient's activities and safety.

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6.3 Refractive Assessment and Prescribing

Description

Assessing the patient's refractive error and, where required, *prescribing* **(OPR 5.2)** an optical correction is an integral part of optometric care. Assessment methods include objective and subjective techniques.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The process of obtaining *required clinical information* **(OPR 4.2)** includes determination of the refractive status and best-corrected visual acuities. When possible, objective and subjective refraction techniques are used to assess the refractive status of the eye, at the initial visit and as clinically indicated thereafter. *Cycloplegic refraction* is employed when clinically necessary. **(OPR 7.6)**

Refractive assessment alone does not provide sufficient information to allow an optometrist to issue an appropriate prescription for subnormal vision devices, contact lenses or eyeglasses.. The effects of ocular and systemic health conditions, binocular vision status and the occupational and avocational visual environment and demands must also be considered.

The College standard on *delegation and assignment* **(OPR 4.3)** and *collaboration* **(OPR 4.8)** must be followed when refractive data is obtained from a person to whom the procedure has been assigned, including another regulated health professional (RHP). Specifically, there must be direct supervision of the subjective refractive assessment when this procedure is assigned.

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6.4 Spectacle Therapy

Description

Optometrists are authorized to dispense spectacles for the treatment of disorders of refraction and/or sensory and oculomotor disorders and dysfunctions of the eye and vision system. The patient must present a valid prescription written by an optometrist or physician.

Regulatory Standard

Ophthalmic dispensing is defined as "the preparation, adaptation and delivery" of vision correction, and is a controlled act in Ontario authorized to optometrists, physicians and opticians:

- Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses **(Optometry Act, 1991, c.35,s.4)**.

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act, 1991)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which consent is required by law, without such a consent.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

29. Charging pr allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

30. Failing to issue a statement or receipt that itemizes an account for professional goods or services to the patient or a third party who is to pay, in whole or in part, for the goods or services provided to the patient.

33. Charging or accepting a fee, in whole or in part, before providing professional services to a patient unless

i. the fee relates to the cost of professional goods to be used in the course of performing the services, or,

ii. the member informs the patient, before he or she pays the fee, of the patient's right to choose not to pay the fee before the professional services are performed.

Professional Standard

Optometrists providing spectacle therapy must satisfy all Regulatory and Professional Standards, regardless of whether or not technology (including the internet) is used as a tool to facilitate the provision of spectacle therapy to patients.

The provision of spectacle therapy involves:

- **Reviewing with the patient any relevant environmental, occupational, avocational, and/or physical factors affecting spectacle wear:** If this review is not performed in-person, optometrists should include a precaution for patients that in-person reviews are recommended for individuals with special needs or atypical facial and/or postural features. If optometrists choose specific patient factors by which to limit their internet dispensing services, including, but not limited to, a specific age range, this should be disclosed on the website where patients can easily find it.
- **Reviewing the details of the prescription:** Optometrists are responsible for confirming the validity and/or veracity of prescriptions. Prescriptions provided using the internet must be provided in a secure manner and collected in an unaltered form (pdf/image). All prescriptions must contain information that clearly identifies the prescriber (including name, address, telephone number and signature), and specifies the identity of the patient and the date prescribed **(OPR 5.2 The Prescription)**. All prescriptions must include an expiry date.
- **Advising the patient regarding appropriate ophthalmic materials:** In the event that this is not performed in-person, patients must be given clear directions on how to contact the office/optometrist with any questions they may have.
- **Taking appropriate measurements (including but not limited to interpupillary distance and segment height) to ensure proper function of the spectacles:** If computer applications are used (in-office or remotely) to determine dispensing measurements, optometrists must be satisfied that the application determines these measurements with equal accuracy to traditional in-person measurements, including the production of supportable evidence should this matter come to the attention of the College.
- **Confirming the suitability of the order and arranging for the fabrication of the spectacles**
- **Verifying the accuracy of the completed spectacles to ensure that they meet required tolerances**
- **Fitting or adjusting the spectacles to the patient:** Optometrists providing spectacle therapy will possess the equipment required to fit and adjust spectacles. In-person fitting and adjusting of spectacles provides a

final verification and mitigates risk of harm by confirming that patients leave the clinic with spectacles that have been properly verified, fit and adjusted. Further, it establishes a patient/practitioner relationship in circumstances where patients are new to the clinic and spectacle therapy was initiated through the optometrist's website. That being said, patients have the right to agree to, or decline the performance of any procedure, including in-person fitting and adjustment of spectacles. When patients require or request delivery of prescription eyeglasses prior to in-person fitting, optometrists must use their professional judgment in determining whether this is appropriate, with consideration to factors including, but not limited to, the age of the patient, the degree of ametropia and/or anisometropia, and prescribed multifocality or prism.

- **Counselling the patient on aspects of spectacle wear including, but not limited to: the use, expectations, limitations, customary adaptation period and maintenance requirements of the spectacles:** This may be done in person or virtually.

The principle of informed consent applies to spectacle therapy whether the service is provided in-person or virtually. Optometrists use professional judgement in determining when consent must be specifically documented in the patient record. While implied consent can be assumed to apply to the in-person provision of spectacle therapy, the same cannot be said for virtual encounters, when express written documentation of informed consent is preferable.

Additional Considerations

Patients experiencing unexpected difficulty adapting to new spectacles should be counselled to seek re-examination by the prescriber to assess the appropriateness of the prescription. Optometrists dispensing appliances based on a prescription from another practitioner are expected to ensure that this has been filled appropriately, however they are not responsible for the efficacy or accuracy of that practitioner's prescription.

Delegation: Optometrists who delegate elements of spectacle dispensing (for example, the fitting and adjusting of spectacles) to staff who are not authorized to independently perform the controlled act, must be present in the same physical location and able to intervene, unless another optometrist is present to provide appropriate delegation **(OPR 4.3 Delegation and Assignment)**.

Most Responsible Dispenser: In collaborative or multi-optometrist practices, where multiple optometrists may participate in dispensing spectacles to an individual patient, the College considers that the last optometrist to provide care, or "touch the patient", typically the optometrist fitting or adjusting the spectacles, is the most responsible dispenser. This optometrist is responsible for all preceding steps in the dispensing process, as well as the performance of the spectacles and any potential risk of harm to the patient. Similarly, where optometrists practice in working arrangements with opticians, the most responsible dispenser is the last regulated professional to provide care to the patient.

Jurisdiction: Ontario-based optometrists providing care to patients in other jurisdictions (provinces/states) may need to be registered in those jurisdictions and should consult with the appropriate regulatory authorities. Optometrists participating in any aspect of ophthalmic dispensing in Ontario must be registered with the College of Optometrists of Ontario.

The Patient Record: Internet prescriptions and orders must be maintained in the patient record **(OPR 5.1 The Patient Record)**.

Internet Sites: Where the internet is used in the provision of spectacle therapy, websites utilized by member optometrists must:

- comply with College advertising guidelines and relevant paragraphs in the Professional Misconduct regulation **(O. Reg. 119/94, Part I under the Optometry Act)**;
- identify the website as belonging to or referring to a member registered with the College of Optometrists of Ontario;
- collect and record patient information in a private and secure manner respecting patient confidentiality;
- identify the physical location of the clinic/dispensary, including address and city/town, and the hours of operation of the clinic; and
- include the telephone number to contact the clinic/dispensary.

Conflicts of Interest: Under the Optometry Act (O. Reg. 119/94, Part II Conflict of Interest p. 3.(2)(h)), optometrists are prohibited from sharing fees with other than another Ontario-registered optometrist or physician. Optometrists providing spectacle therapy in working arrangements with corporations must not share fees, and must practice as an independent contractor as outlined under the Optometry Act (O. Reg. 119/94, Part II Conflict of Interest p. 4.(5)).

Expired Prescriptions: Optometrists must use professional judgment in determining whether it is appropriate to provide spectacle therapy to patients presenting expired prescriptions. Optometrists must advise patients of any appreciated risks and obtain their informed consent before dispensing their expired prescriptions.

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October 2015
September 2019

6.5 Contact Lens Therapy

Description

Optometrists are authorized to prescribe and dispense contact lenses for the treatment of:

- disorders of refraction, and/or sensory and oculomotor dysfunctions of the eye and vision system, and/or
- diseases/disorders affecting ocular health, and/or
- anatomical, structural and/or cosmetic concerns

The provision of this service to patients involves an initial assessment to determine suitability of patients for contact lens therapy, a determination of the parameters of a contact lens appropriate for patients, and ongoing monitoring of the efficacy of treatment. Contact lenses are classified by Health Canada as a medical device, not a consumer commodity, and should be treated accordingly.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Initial Contact Lens Fitting

Before contact lens fittings, optometrists obtain required clinical information **(OPR 4.2)** to determine the suitability of patients for contact lens wear. Special emphasis is given to the analysis of:

- the health of the cornea, conjunctiva, lids, tarsal and bulbar conjunctiva, and the integrity of the tear layer;

- corneal curvature;
- refractive status and visual acuity;
- the effects that contact lens wear may have on the function of the accommodative, oculo-motor and sensory systems; and
- relevant environmental, occupational, avocational, emotional and systemic health factors affecting contact lens wear.

To allow patients to make informed decisions about proceeding with treatment, optometrists provide information about the advantages, risks, limitations, and costs of contact lens wear and on the prognosis for successful treatment. Patients may choose to proceed with the contact lens fitting by their optometrist, or may obtain a copy of the spectacle prescription to be used for contact lens fitting by other qualified practitioners.

In fitting contact lenses, optometrists will determine, by diagnostic fitting or calculation, lenses that are appropriate for their patients. The initial lenses are evaluated on a patient's eyes and subsequent modifications of the lens parameters are made as required.

Instructions are provided to patients with respect to:

- hygiene;
- lens insertion and removal;
- use of specific lens care products;
- recommended wearing times and replacement schedules;
- normal and abnormal adaptive symptoms;
- contraindications to lens use;
- progress evaluations; and
- appropriate instructions on how and when to access emergency care **(OPR 4.6)**.

Patients are examined during the adaptation period to assess lens performance, adaptation and compliance.

Once optometrists are satisfied that the adaptation process is complete, and that the parameters of the contact lenses are correct, a contact lens prescription can be finalized. Optometrists are entitled to remuneration for all professional services involved in the determination of these prescriptions. At this point, patients have the option of obtaining contact lenses from their optometrist, or requesting a copy of the contact lens prescription in order to obtain contact lenses elsewhere.

Continuing Care

Optometrists provide continuing care to established contact lens patients. In providing continuing care, optometrists:

- maintain a history concerning:
  - the specifications, age and wearing schedule of current contact lenses;
  - the current lens care regime;
  - any adverse reactions associated with contact lens wear; and

    - any health or medication changes.

- assess patients to determine if they are achieving acceptable:
    - lens appearance and fit;
    - wearing time;
    - comfort with lenses in place;
    - corneal clarity and integrity;
    - conjunctival and lid appearance;
    - tear characteristics;
    - over-refraction for best visual acuity;
    - spectacle acuity; and
    - compliance with recommendations on lens handling, lens care, lens replacement and wearing times.
- identify any problems and counsel patients as necessary.
- provide and implement management plans for any problems identified, making recommendations for further care.

Replacement Contact Lens Services

When providing replacement contact lens services, optometrists are responsible for:

- determining the currency of clinical information and providing diagnostic services as required;
- determining the need for alteration of previous lens specifications and makes adjustments accordingly;
- advising patients as to the need for and extent of continuing care;
- confirming the parameters of contact lenses as ordered; and
- providing follow-up services as needed.

The College standards on Delegation and Assignment **(OPR 4.3)** and Collaboration **(OPR 4.8)** must be followed when any procedures are assigned, including to another regulated health professional (RHP).

Internet Sites

Where the internet is used in the provision of contact lens therapy, websites must:

- comply with College advertising guidelines and relevant paragraphs in the Professional Misconduct regulation (O. Reg. 119/94, Part I under the Optometry Act);
- identify the website as belonging to or referring to a member registered with the College of Optometrists of Ontario;
- collect and record patient information in a private and secure manner respecting patient confidentiality;

- identify the physical location of the clinic/dispensary, including address and city/town, and the hours of operation of the clinic; and
- include the telephone number to contact the clinic/dispensary.

The College standards on Delegation and Assignment **(OPR 4.3)** and Collaboration (OPR 4.8) must be followed when any procedures are assigned, including to another regulated health professional (RHP).

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September 2014
June 2018

6.6 Low Vision Assessment and Therapy

Description

Patients are considered to be visually impaired when there is a measurable loss of vision, including but not limited to visual acuity, contrast sensitivity, and visual field.

Patients are considered to have low vision when their visual impairment results in a reduction in best-corrected visual acuity or visual field that is inadequate for their activities of daily living.[1,2,3]

Patients with low vision may benefit from a low vision evaluation. This includes review of ocular and general (systemic) health conditions, identification of patient-defined goals, extended evaluation of visual function, prescription of and training in the use of various optical and/or non-optical low vision aids and/or rehabilitation strategies directed towards previously-defined patient-defined goals, and counseling and education.

The need for a low vision evaluation will generally be determined as the result of an exploration of patient-reported limitations and goals, and will be informed by specific clinical findings from a comprehensive optometric examination **(see OPR 4.2 - Required Clinical Information)**.

Other reasons for conducting a low vision evaluation include but are not limited to referral from another practitioner or direct referral from a patient or family member. Repeat or ongoing examinations may be required to determine the response to the rehabilitation plan or to monitor the status of patients with low vision.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

24. Failing to make or maintain records in accordance with Part IV.

Professional Standard

A low vision examination generally will include the following components:

- a comprehensive patient history that explores:
  - personal ocular and general health history (including medications);
  - family ocular and general health history;
  - personal social history, including patient-identified impact of visual impairment (specific limitations in activities of daily living and goals (vocational/educational/avocational requirements));
  - personal perspective regarding stability of vision;
  - current access to services;
  - current devices and usage/satisfaction;
- consideration of common issues that affect people with low vision;
- a review of the results of the patient's most recent optometric examination, and re-assessment, as necessary;
- patient education regarding visual status, treatment options, and prognosis;
- assessment of rehabilitation options that includes discussion and/or demonstration of potential optical, non-optical, and electronic aids and devices, lighting requirements, environmental modifications, and adaptive strategies;
- creation of a rehabilitation plan individualized for the patient's needs;
- referral to other professionals/service providers, as indicated;
- generation of a report to individuals in the patient's circle of care, when indicated; and
- appropriate follow-up, arranged as needed, to assess the effectiveness of the rehabilitation plan and to monitor the visual condition and needs.

1. Leat SJ, Legge G, Bullimore M. What is low vision - a re-evaluation of definitions. Optom. Vis. Sci. 1999; 76:198-210.
2. THE ICF: AN OVERVIEW **https://www.cdc.gov/nchs/data/icd/icfoverview_finalforwho10sept.pdf**
3. Strong G Jutai J, Plotkin A, Bevers P. Competitive enablement: a consumer -oriented approach to device selection in device-assisted vision rehabilitation. Aging Disability & Independence. 2008; 175-195.

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April 2019

6.7 Binocular Vision Assessment and Therapy

Description

Binocular vision is defined as the ability to maintain visual focus on an object with both eyes, creating a single visual image. Binocular vision enables good depth perception and allows clear, comfortable vision to be maintained throughout visual activities. Optometrists diagnose and treat both congenital and acquired disorders of binocular vision. Clinically, binocular vision is assessed through investigation of the oculomotor and sensory systems.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The initial binocular vision assessment includes:

- appropriate case history;
- refraction and determination of best-corrected visual acuities, including use of cycloplegic **(OPR 7.6)** agents, when indicated;
- assessment of ocular alignment and comitancy;
- assessment of ocular motility;
- assessment of saccadic and pursuit function;
- assessment of vergence function;
- assessment of accommodative function;
- assessment of sensory function;
- identification of postural adaptations, including anomalous head posture, if present,
- assessment of nystagmus, if present;
- consideration of etiology (congenital versus acquired disorders).

The initial binocular vision assessment includes distance and nearpoint testing in primary gaze, at minimum. Follow-up evaluations may be limited to re-assessment of pertinent areas of binocular function.

Management of binocular vision disorders includes:

- refractive and prismatic corrections;
- full or partial occlusion;
- amblyopia **(OPR 7.12)** therapy;
- vision therapy;
- periodic monitoring of the condition;
- collaboration with other service providers involved, including educators, occupational and physical therapists, physicians, neurologists, etc.; and/or
- tertiary care referral **(OPR 4.5)**, including but not limited to surgery and/or imaging, when indicated.

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6.8 Visual Field Assessment

Description

Assessment of the field of vision is an essential part of evaluation of the oculo-visual system. Assessment strategies used may be either screening or detailed (threshold) in nature, utilizing manual or computerized instruments and can assess patients' central and/or peripheral field of vision. Visual field assessment is used in the diagnosis and monitoring of conditions of the eye and vision system including, but not limited to, glaucoma, neurological and retinal disease, and to fulfil third party reporting requirements. Information obtained from visual field assessment and analysis is part of the patient health record **(OPR 5.1)** and must be retained.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or health-related purpose in a situation in which a consent is required by law, without such consent

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice for the profession.

Professional Standard

The required clinical information **(OPR 4.2)** includes the results and analysis of visual field assessment when indicated by patient signs, symptoms or history. The nature of the signs, symptoms or history will determine the test strategy used and the frequency of re-assessment.

Indications for visual field assessment include, but are not limited to:

- assessment of visual disability
- assessment of patients' ability to operate a motor vehicle
- unexplained headaches
- unexplained photopsia or other visual disturbances
- use of medications with potential neuro-ophthalmic toxicity
- eyelid or anterior segment anomalies that may affect the visual field

- some retinal diseases and abnormalities
- glaucoma or risk factors for glaucoma
- diseases of the optic nerve and visual pathway
- neurological disease

Visual field screening provides a rapid assessment of the sensitivity and/or extent of the visual field to determine if a more detailed evaluation of the visual field is required. Screening strategies include, but are not limited to:

- confrontation methods
- amsler grid
- tangent screen and arc perimeter methods
- automated techniques specifically designed for screening

When a more detailed evaluation is required, it is appropriate to utilize techniques including but not limited to:

- Goldmann perimetry (kinetic and/or static)
- automated threshold perimetry

If optometrists do not have the required instrumentation, arrangements must be in place whereby the appropriate testing will be performed elsewhere in a timely fashion. A requisition for visual field testing must include the visual field test strategy requested and pertinent clinical information. Upon receipt of visual field results, the optometrist providing ongoing care will communicate the results to patients in a timely fashion.

Optometrists accepting requisitions for visual field assessments where the requesting optometrist does not have the required instrumentation, must maintain a patient health record including the requisition information and visual field test results. The optometrist who provides the testing is responsible for the performance of the testing. The optometrist who accepts the requisition is not responsible for the interpretation of the results, and the communication of the results to the patient.

Optometrists, accepting referrals and assuming the ongoing care for patients who require visual field testing, must review the results of the patient's optometric and/or medical examination(s) as provided by the referring practitioner, and assess, or re-assess, should any additional clinical information or clarification be necessary.

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7. Specific Diseases, Disorders and Procedures

7.1 Patients with Age-related Macular Degeneration

Description

Age-related Macular Degeneration (AMD) is an acquired retinal disorder that affects central visual function. Nonexudative AMD, also known as "dry" AMD, results in a gradual, progressive loss of central visual functioning, whereas patients with exudative AMD, also known as "wet" AMD, notice a more profound and rapid decrease in central visual functioning.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg.119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

In addition to required clinical information, the evaluation of patients with retinal changes suggestive of AMD, or patients suspected of having AMD, includes:

- patient history of any symptoms associated with AMD; and
- ocular examination including the following:
  - measurement of best corrected monocular visual acuity, distance and near;
  - additional assessment of macular function (for example Amsler grid testing); and
  - posterior segment examination with pupilary dilation **(OPR 6.2)**.

The management of patients with AMD includes:

- continued assessment for differential diagnosis;
- monitoring patients at a frequency that is dependent on the risk of progression of the disease;

- educating patients to be aware of symptoms such as decreased vision, scotomata and dysmorphopsia by monocular assessment;
- educating patients on the potential benefits of the use of supplements (vitamins, antioxidants) where clinically indicated;
- educating patients on the benefit of lifestyle changes (use of UV protection, cessation of smoking) where indicated;
- instructing patients on the importance of monitoring for the onset of new symptoms between in-office assessments, and to return immediately for assessment should they be noted; and
- making a timely referral **(OPR 4.5)** for treatment assessment for patients suspected of having choroidal neovascularization (CNV), particularly given the advent of anti-vascular endothelial growth factor (anti-VEGF) treatments that may afford an improvement in central vision.

In developing a treatment plan, consideration should be given to the patient's visual demands and abilities.

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7.2 Patients with Glaucoma

Description

Glaucoma* is a clinical term referring to a spectrum of conditions resulting in damage to the optic nerve and progressive reduction in sensitivity within the field of vision. Patients with glaucoma or patients with significant risks of having glaucoma (hereafter referred to as "glaucoma suspects" for consistency with current professional literature) are commonly encountered in optometric practice. Early diagnosis and therapy may reduce the rate of progression of this disease.

When glaucoma develops without an identifiable cause, it is termed primary.1 Primary open angle glaucoma is the most common form of this disease and may be managed by optometrists with therapeutic qualifications. Glaucoma with an identifiable cause is termed secondary.

Regulatory Standard

The Optometry Act, 1991 states that in the course of engaging in the practice of optometry optometrists are authorized, subject to terms, conditions and limitations imposed on his or her certificate of registration, to perform the following controlled act:

2.1 Prescribing drugs designated in the regulations.

The Designated Drugs and Standards of Practice Regulation **(O. Reg. 112/11 under the Optometry Act)** describes the following conditions under which an optometrist may prescribe drugs for the treatment of glaucoma:

PART II

STANDARDS OF PRACTICE — GLAUCOMA

Prescribing of antiglaucoma agents

6. It is a standard of practice of the profession that in treating glaucoma a member may only prescribe a drug set out under the category of "Antiglaucoma Agents" in Schedule 1.

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* Glaucoma is a clinical term referring to a variety of conditions with the common feature of an optic neuropathy (i.e. glaucomatous optic neuropathy [GON]) characterized by a distinctive loss of retinal nerve fibres and optic nerve changes. GON can develop under a number of circumstances with varying contributions by several known and as yet unidentified risk factors. The clinical term glaucoma is sometimes used when 1 risk factor, elevated intraocular pressure (IOP) is very extreme and GON is impending but not yet present (i.e. acute glaucoma). Glaucoma is often pluralized to reflect the variety of clinical presentations of this optic neuropathy. (Canadian Ophthalmological Society)2. rev:20170123

Open-angle glaucoma

7. 1) Subject to subsection (2) and to section 8, it is a standard of practice of the profession that a member may only treat a patient with glaucoma where the patient has primary open-angle glaucoma the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment.

2) It is a standard of practice of the profession that a member may only treat a patient having open-angle glaucoma, the treatment of which is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment, in collaboration with a physician with whom the member has established a co-management model of care for that patient and who is,

(a) certified by the Royal College of Physicians and Surgeons of Canada as a specialist in ophthalmology; or

(b) formally recognized in writing by the College of Physicians and Surgeons of Ontario as a specialist in ophthalmology.

Referral to physician or hospital

8. (1) Subject to subsections (2) and (3), it is a standard of practice of the profession that a member shall immediately refer a patient having a form of glaucoma other than primary open angle glaucoma to a physician or to a hospital.

(2)It is a standard of practice of the profession that a member may initiate treatment for a patient having angle-closure glaucoma only in an emergency and where no physician is available to treat the patient.

(3) It is a standard of practice of the profession that a member shall immediately refer any patient being treated in accordance with subsection (2) to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

(4) In this section,"hospital" means a hospital within the meaning of the Public Hospitals Act.

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be knowledgeable and competent in the diagnosis and management of glaucoma.

The examination of patients with either glaucoma, or a suspicion of developing glaucoma, must include an appropriate assessment of any patient-specific risk factors. The core considerations for the diagnosis and management of glaucoma include:

- case history with attention to risk factors for glaucoma
- biomicroscopic examination of the anterior segment and anterior chamber angle
- measurement of the intraocular pressure
- evaluation and description of the optic nerve head through dilated pupils **(OPR 6.2)**
- gonioscopy*
- investigation of threshold visual fields*; and
- measurement of central corneal thickness, when clinically indicated.

*These tests may not be required if the patient's signs and/or symptoms indicate a referral to a secondary or tertiary eye care provider for the continuing diagnosis and/or management of glaucoma.

Members are expected to use instrumentation and techniques consistent with current professional standards of practice.

Management Options

For patients with glaucoma or glaucoma suspects, options include:

1. follow-up examinations at suitable intervals

2. drug therapy when indicated:

   a. by referral to an ophthalmologist,

   b. by an optometrist with authority to prescribe drugs for the treatment of primary open angle glaucoma

   c. by an optometrist with authority to prescribe drugs in collaboration **(OPR 4.8)** with an ophthalmologist for the treatment of primary open angle glaucoma when complicated by a concurrent medical condition or potentially interacting pharmacological treatment;

d. by referral to a physician or hospital, for secondary glaucomas

e. the immediate application of drugs in an emergency situation, such as angle-closure glaucoma, where no physician is available, then, immediately refer the patient to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

Optometrists must discuss the appropriate option(s) with the patient and obtain informed consent.

The management plan must be clearly documented in the *patient health record* **(OPR 5.1)**

In summary:

Optometrists with authority to prescribe drugs are required to refer patients with primary open angle glaucoma to an ophthalmologist if the treatment is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment. Treatment may be provided in collaboration with an ophthalmologist with whom the member has established a co-management model of care for that patient.

Optometrists are required to refer patients with secondary glaucoma to a physician or hospital.

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January 2018

7.3 Patients with Cataract

Description

The practice of optometry includes the diagnosis, care and, when appropriate, referral of patients with cataract. Optometrists also work in collaborative arrangements **(OPR 4.8)** providing preoperative and postoperative care to patients requiring cataract surgery.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

9. Making a misrepresentation with respect to a remedy, treatment or device.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

19. Performing a controlled act that the member is not authorized to perform.

Professional Standard

When providing care to patients with cataract, optometrists will:

- have the required knowledge, skill and judgement to diagnose and appropriately manage patients with cataract;
- utilize appropriate instrumentation and techniques to diagnose cataract and identify any ocular or systemic conditions that may complicate the surgical procedure or limit the postsurgical visual outcome. As a minimum, these techniques would include the taking of a thorough ocular and systemic history (including medications) as well as refraction, slit lamp examination and funduscopic examination;
- counsel patients regarding their visual status and recommend surgical referral when appropriate;
- arrange *referral* **(OPR 4.5)** as required;
- disclose to patients any financial interest in a surgical centre to which patients are referred;

- comply with the College standards on collaboration/shared care when providing preoperative and/or postoperative care to patients **(OPR 4.8)**; and
- comply with College standards on delegation when performing a controlled act that is outside the scope of practice of optometry. **(OPR 4.3)**

Last Reviewed: June 2017

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September 2017

7.4 Patients with Diabetes

Description

Diabetes mellitus (DM) is a very common systemic condition that can have numerous ocular manifestations. While retinopathy and macular edema pose the greatest long-term threat to vision for most patients with diabetes, optometrists should also be alert to the development of many other possible complications ranging from transient fluctuations in refractive error and dysfunctions of accommodation and colour vision, to abnormalities in the cornea, iris, retina, lens, vitreous, and optic nerve. Also, neuro ophthalmic conditions/anomalies may arise from neuropathies affecting cranial nerves.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Due to the high prevalence of ocular manifestations of diabetes and the increasing incidence of retinopathy as the duration of the disease increases, all patients with diabetes require periodic assessment of the eye and vision system. Patients are advised as to the appropriate frequency of such assessments, depending on factors such as the duration of the disease, the nature of the condition (e.g. Type I versus Type II), the quality of blood glucose control, and the clinical findings. The normal complement of required clinical information **(OPR 4.2)** is updated regularly with particular emphasis on a detailed case history and thorough anterior and posterior segment examination with pharmacological pupil dilation. Any abnormalities found are carefully documented in the patient record.

Optometrists should be familiar with the classification and current management standards for the various stages of diabetic retinopathy. *Referral* **(OPR 4.5)** to an appropriate healthcare professional is required when indicated.

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June 2015

January 2019

7.5 Patients with Systemic Hypertension

Description

A number of ocular diseases are directly or indirectly associated with systemic hypertension. Hypertensive retinopathy is the most common direct ocular consequence, while hypertensive choroidopathy and optic neuropathy are less common sequelae. Hypertension is a risk factor for the development of retinal artery and vein occlusions and extraocular muscle palsies, and can increase the risk and severity of age-related macular degeneration, diabetic retinopathy, and glaucoma (the latter may also be affected by the aggressive treatment of systemic hypertension). A collaborative approach with medicine is needed for the management of patients with systemic hypertension who have ocular complications.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The frequency of assessments of the eye and vision system depends on factors such as the history and status of the condition, the clinical findings, and the presence of other cardiovascular risk factors, most commonly dyslipidemia and diabetes. Any abnormalities found are documented and the patient's primary healthcare practitioner (such as family physician, or nurse practitioner) is advised as necessary of any findings that may pose a threat to the patient's ocular or systemic health.

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June 2014

January 2019

7.6 Cycloplegic Refraction

Description

Objective and subjective refraction done under cycloplegia can provide useful information in situations where sustained accommodative effort is suspected to be contributing to symptoms or obscuring a full diagnosis of the clinical problem.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Cycloplegic refraction is indicated on the initial assessment of children and young adults, including but not limited to those:

- with suspected clinically significant latent hyperopia;
- with unexplained reduced visual acuity;
- with suspected amblyopia; or
- who are at risk of developing amblyopia secondary to accommodative esotropia or asymmetric refractive error.

Cycloplecic refraction is repeated when clinically indicated.

When *using cycloplegic agents* **(OPR 4.4)**, optometrists will:

- be familiar with the properties of any cycloplegic agents they use;
- counsel patients appropriately regarding the expected effects and anticipated duration of action of the agent; and
- consider the presence of any significant contraindications to the use of a cycloplegic agent prior to instillation (e.g., narrow anterior chamber angle, past history of angle closure attacks or other adverse reactions or hypersensitivities to similar agents, etc.).

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7.7 Dilation and Irrigation of the Naso-Lacrimal Ducts

Description

Dilation and irrigation of the naso-lacrimal ducts may be used as diagnostic or treatment procedures. These procedures temporarily enlarge the punctal opening to the canaliculi for insertion of occlusion devices and/or the irrigation of material from the canaliculi and the naso-lacrimal ducts and/or to maintain complete patency of the system.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Members providing this service must be competent in performing this technique and have a thorough understanding of the anatomical features and fluid dynamics of the lacrimal system to determine the location of an obstruction.

- dilation and irrigation of the naso-lacrimal ducts will follow a diagnostic process to determine if the procedure is warranted.
- appropriate infection controls must be used.

Last Reviewed: September 2017

First Published: September 2006

Revised: April 2014

7.8 Shared Care in Refractive Surgery

Description

The term 'Refractive Surgery' (RS) is a general term for the various forms of surgery used to correct refractive errors of the eye. This includes techniques that use lasers and other forms of electromagnetic energy, implantable lenses and devices, and incisional techniques. Optometrists provide preoperative and postoperative care to RS patients both in their offices and within surgical centres.

Refractive surgery is one of the situations in which optometrists often participate in a shared care relationship **(OPR 4.8)** with another healthcare practitioner. Shared care arrangements are intended to assist in the delivery of effective, efficient, high quality patient care. This standard and guideline addresses the sharing of responsibilities, the communication of patient information, and the financial arrangements within shared care situations.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

9. Making a misrepresentation with respect to a remedy, treatment or device.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

16. Performing a controlled act that the member is not authorized to perform.

Conflict of Interest **(O. Reg. 119/94 Part II under the Optometry Act)** includes the following conflicts of interest:

3. (1) A member shall not engage in the practice of the profession while the member is in a conflict of interest. **O. Reg. 24/14, s. 1.**

(2) A member is in a conflict of interest where the member,

(a) Has a personal or financial interest that influences or is likely to influence the exercise of the member's professional expertise or judgment in respect of the treatment or referral of a patient;

(d) accepts a benefit that is related to the member referring a patient to any other person;

(h) shares fees related to the practice of the profession with any person other than,

(i) another member, or

(ii) a member of the College of Physicians and Surgeons of Ontario engaged in the practice of medicine. **O. Reg. 24/14, s. 1.**

Professional Standard

Optometrists providing care to patients pursuing RS will:

- maintain current knowledge of surgical procedures and competence in delivering the various types of preoperative and postoperative procedures in which they participate;
- acquire the normal complement of required clinical information **(OPR 4.2)**;
- identify preoperative ocular health, binocular, refractive or systemic conditions that may complicate the surgical procedure or limit the postsurgical outcome;
- inform patients of the various risks and benefits of the procedure, their options for care providers and all associated fees;
- make a referral **(OPR 4.5)** to an ophthalmic surgeon that includes relevant history and clinical findings;
- follow postoperative protocols indicated by refractive surgeons;
- disclose to patients any financial interest in a surgical centre to which the optometrist refers the patient; and
- comply with the College standards on collaboration/shared care **(OPR 4.8)** and delegation **(OPR 4.3)**.

Last Reviewed: February 2014 First Published: September 2006

Revised: June 2014

7.9 Patients with Learning Disability

Description

Learning disability is a condition where a significant discrepancy exists between the potential for learning and the actual academic or vocational achievement. Patients with suspected or recognized learning disability often consult optometrists to determine whether a vision problem could be a contributing factor.

By assessing and managing vision problems associated with learning disability, optometrists act as members of a multidisciplinary team that may also include one or more of the following professionals:

- another optometrist who is proficient in visual information processing (visual perception) evaluation;
- educator;
- psychologist;
- physician;
- occupational therapist;
- audiologist; and/or
- speech-language pathologist.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

29. Charging or allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

Professional Standard

All patients with suspected or recognized learning disability require initial and periodic assessment of the eye and vision system. The frequency of such assessments depends on factors such as the history and clinical findings, and the visual demands of the patient's academic /vocational circumstances.

The normal complement of *required clinical information* **(OPR 4.2)** is obtained and updated regularly with particular emphasis on a detailed case history and careful *refractive assessment* **(OPR 6.3)**, and consideration of the need for *cycloplegic refraction* **(OPR 7.6)** and *binocular vision assessment* **(OPR 6.6).**

Where such services are available, optometrists will provide counsel to patients regarding options for further investigation and/or consultation with another professional, as appropriate under the circumstances. Any notable concerns will be communicated to the appropriate team member.

Last Reviewed: January 2013 First Published: April 2012

Revised: April 2014

7.10 Orthokeratology

Description

Orthokeratology (Ortho-K) involves the wearing of specially designed rigid gas permeable (RGP) contact lenses, often overnight, to progressively and temporarily alter the curvature of the cornea. This procedure may be offered by optometrists as an option for vision correction (most commonly myopia and/or astigmatism), and is being investigated for myopia control in children.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

8. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

15. Delegating a controlled act in contravention of the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.

22. Publishing or using, or knowingly permitting the publication or use of an advertisement or announcement or information that promotes or relates to the provision of professional services by a member to the public, whether in a document, business card, business sign, website, or any other format, which,

i. is false or deceptive, whether by reason of inclusion or of omission of

information,

ii. suggests that the member is a specialist or is specially educated, trained or qualified other than where the reference is to an educatioal acheivement and the reference has been approved by Council.

v. is not factual, objectively verifiable or readily comprehensible to the persons to whom it is directed.

Professional Standard

Optometrists performing Ortho-K must be competent in the fitting of RGP contact lenses and follow the contact lens standards outlined in section 6.5 of the OPR. They must stay abreast of developments in Ortho-K technologies, and consult peer-reviewed literature and professionally developed practice guidelines.

Optometrists must present a realistic prognosis when offering Ortho-K, especially as it pertains to the amount of myopia reduction and/or control possible for patients. The risks, as well as benefits, of corneal reshaping procedures and overnight contact lens wear must be explained to prospective patients and these individuals must be carefully monitored, both through the initial wear phase as well as the retainer wear phase. In addition, patients must be counseled to be compliant with lens care, wearing schedule instructions, and follow-up assessments.

The full complement of required clinical information may not be necessary when providing specific assessments or consultation services for referring optometrists, physicians or nurse practitioners. In such cases, optometrists will determine what is clinically necessary based on the reason for presentation. **(OPR 4.2)**

Optometrists accepting referrals for Ortho-K must review the results of the referring practitioner's optometric and/or medical examination(s), and assess, or re-assess the referred patient, should any additional clinical information or clarification be necessary.

Preliminary and ongoing examination follows the standards articulated in Contact Lens Therapy **(OPR 6.5)**, and also includes:

- refraction and visual acuities (unaided and best corrected)
- corneal topography measurements (pre-treatment, during follow-up until refractive stability is achieved, and thereafter at the discretion of the practitioner)

Consent

Optometrists must obtain informed consent from patients, including information regarding the fitting method, concerns and precautions of overnight contact lens wear, realistic expectations, the pre-and post-fitting appointment obligations, the itemized costs involved, the warranty/exchange of material policies, and what to do in the event of an emergency. If patients are incapable of providing consent (i.e.

young children undergoing Ortho-K for myopia control), consent must be obtained from their substitute decision-makers (usually a parent in the previous example).

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Revised: April 2014

7.11 Patients With Dry Eye Disease

Description

Dry eye disease (DED) is a complex disorder, as noted in the contemporary definition articulated by the Tear Film and Ocular Surface Society Dry Eye Workshop II (TFOS DEWS II)[1] in 2017:

> *'Dry eye is a multifactorial disease of the ocular surface characterized by a loss of homeostasis of the tear film, and accompanied by ocular symptoms, in which tear film instability and hyperosmolarity, ocular surface inflammation and damage, and neurosensory abnormalities play etiological roles.'*

Although DED can be broadly categorized as aqueous deficient dry eye (ADDE, secondary to inadequate tear production primarily due to lacrimal gland insufficiency) or evaporative dry eye (EDE, secondary to excessive tear evaporation primarily due to meibomian gland dysfunction (MGD)), these conditions exist on a continuum and are not mutually exclusive. In fact, patients typically present with mixed-mechanism disease. Regardless of etiology, the common endpoints of DED include tear film instability, hyperosmolarity, and inflammation leading to variable signs and symptoms that are frequently discordant (that is, one may exist in the absence of the other), and may be episodic or chronic.

A number of tests to diagnose and establish the severity of DED are available. Like signs and symptoms, the results of these tests are often dissonant, but inform patient-specific management strategies aimed at re-establishing tear film and ocular surface homeostasis.

A detailed discussion of diagnosis and management of DED is beyond the scope of this document: a brief synopsis is provided under Professional Standard (below), and the reader is referred to the TFOS DEWS II Report for its comprehensive review **(https://www.tearfilm.org/dettreports-tfos_dews_ii_report/32_30/eng/)**.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes

or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The DED assessment begins with the case history, with special attention to risk factors including but not limited to older age, female sex, general health conditions (including but not limited to connective tissue and autoimmune disease), topical and systemic medications (including but not limited to antihistamines, antidepressants, diuretics, and preservatives accompanying topical medications), environment, and occupational/avocational demands (including but not limited to computer use and contact lens wear).

Patients are questioned regarding symptoms suggestive of DED: the use of a validated questionnaire may be helpful.

Optometrists must perform a clinical examination of the anterior segment of the eye **(OPR 6.1)**, with special attention to eyelid anatomy and health, the blink mechanism, meibomian gland integrity and function, and the integrity of the precorneal tear film and cornea itself. The presence of reduced tear break-up time, elevated or interocular asymmetry in tear osmolarity, or ocular surface staining are signs of the loss of homeostasis that characterizes DED. Optometrists recognize that signs and symptoms of DED are often discordant and that no single diagnostic test can be relied upon to the exclusion of others.

Treatment of DED aims to restore homeostasis of the tear film and ocular surface. It involves a staged, step-wise approach that includes but is not limited to:

- education about DED, and its management and prognosis;
- recommending modification of the patient's environment (including but not limited to increasing humidity, reducing air movement, and encouraging frequent breaks from prolonged use of digital devices), and considering alternative topical and/or systemic medications when feasible;
- use of non-prescription lubricating agents (artificial tears) of varying viscosities (solutions, emulsions, gels, and ointments) and/or osmolarities, including consideration of preserved versus non-preserved products (including autologous serum tears) and the component of the natural tear layer deemed most deficient;
- encouraging and providing instruction for proper eyelid hygiene (both in-office and home-based treatment of meibomian gland dysfunction may be considered);
- recommending the use of oral OTC products (including but not limited to polyunsaturated (omega-3) fatty acid supplements);

- employing mechanisms to promote retention of natural and artificial tears (including but not limited to the use of punctal occlusion (only when concurrent inflammation is under control), or moisture goggles);
- judicious use of topical and/or systemic prescription medications (including but not limited to topical anti-inflammatory and antibiotic agents, and oral antibiotics with anti-inflammatory properties (tetracyclines and macrolides)) within the parameters established by Ontario Regulation 112/11 – Designated Drugs and Standards of Practice **(OPR 4.4);**
- the use of therapeutic contact lenses (including but not limited to the use of bandage soft or scleral contact lenses) or amniotic membranes.

Depending upon the severity of DED and its response to treatment, referral **(OPR 4.5)** to another regulated health professional for further assessment and medical and/or surgical intervention may be necessary.

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[1]Craig JP, et al. TFOS DEWS II Report Executive Summary. The Ocular Surface 2017;15:802-12.

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Revised: June 2015
July 2019

7.12 Patients With Amblyopia

Description

Amblyopia (lazy eye) is characterized by reduced best-corrected visual acuity in one or both eyes, without disease or structural abnormality of the eye or visual pathways. It is caused by an interruption of visual sensory stimulation (due to strabismus, uncorrected refractive error or visual deprivation) occurring early in life during the visual-sensitive period. Children and adults with amblyopia commonly experience reduced vision and eye co-ordination that may impact academic, recreational and occupational accomplishments. Optometrists provide diagnosis and treatment of amblyopia, its causes and associated functional visual deficits.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

8. Failing to reveal the exact nature of a secret remedy or treatment used by member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

29. Charging or allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

Professional Standard

Diagnostic evaluation of new patients with, or suspected of having, amblyopia incorporates:

- comprehensive case history including:
    - prior eye conditions, diseases and treatments

  - family history of amblyopia, strabismus and other eye conditions
  - developmental history including birth weight, pre-/peri-natal history (specifically alcohol, tobacco or drug use during pregnancy), as indicated
- visual acuity
- cycloplegic refraction **(OPR 7.6)**
- ocular motility and alignment
- dilated anterior and posterior segment examinations **(OPR 6.1 and OPR 6.2)**

Given that amblyopia is considered a diagnosis of exclusion, additional investigations are performed as needed to rule out other causes of reduced vision.

Treatment for amblyopia involves:

- consideration of prognostic factors (including but not limited to patient age, cause of amblyopia, degree of amblyopia) and patient education regarding realistic goals, limitations and estimated time frame of available treatment options
- optical correction, as required
- occlusion treatment or pharmacological penalization, as indicated
- vision therapy for monocular and binocular visual function, as required
- referral **(OPR 4.5)** for surgical correction of associated conditions (such as strabismus, ptosis, etc.), as indicated
- patient education regarding the impact of amblyopia on eligibility for specific occupations, increased risk for eye injury and the importance of eye protection
- provision of a prescription for protective eyewear

Continuing care of established patients previously diagnosed with amblyopia is done at appropriate intervals. Patients involved in active amblyopia therapy are seen frequently, to assess progress and modify treatment as needed, while others are seen regularly, as indicated. Continuing care includes:

- history concerning any changes in vision or visual function and patient compliance with prescribed treatment
- re-assessment of best-corrected visual acuity and binocular status
- re-assessment of ocular health status with special attention to the ongoing health of the non-amblyopic eye
- modification of the treatment plan, as indicated, to improve the effectiveness of treatment and/or to better meet patient needs and expectations

Optometrists must stay abreast of developments in evidence-based treatment for amblyopia and ensure that their patients have access to such treatment where clinically beneficial.

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7.13 Patients With Uveitis

Description

Uveitis is an inflammatory condition of the eye that may be classified anatomically (based on the part of the eye primarily affected) as anterior, intermediate, posterior, or panuveitic, or based on duration as acute when the condition lasts less than two months, chronic when it lasts longer than two months, or as recurrent when repeated episodes are separated by several months of inactivity.

Anterior uveitis, also known as **iridocyclitis** or **iritis**, is inflammation of the iris and ciliary body. As many as 90% of uveitis cases are anterior in location.

Intermediate uveitis, also known as **pars planitis**, is inflammation of the vitreous cavity (vitritis) sometimes with snowbanking, or deposition of inflammatory material on the pars plana.

Posterior uveitis, also known as **chorioditis**, is inflammation of the choroid that may secondarily involve the retina (chorioretinitis).

Panuveitis is inflammation of the entire uveal tract involving both the anterior segment (iris and ciliary body) and the posterior segment (choroid).

These conditions may occur as a single episode, subsiding spontaneously or with proper treatment, or may become chronic or recurrent in nature.

The practice of optometry includes the diagnosis, treatment and, when appropriate, referral of patients with uveitis.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

8. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to

require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

16. Performing a controlled act that the member is not authorized to perform.

Professional Standard

When providing care to patients with uveitis, optometrists will:

- have the required knowledge, skill and judgment to appropriately diagnose, treat and/or refer patients with uveitis
- utilize appropriate instrumentation and techniques to diagnose uveitis and identify any ocular or systemic conditions that may complicate the condition. As a minimum, this would include:
  - a thorough ocular and systemic history
  - unaided and/or best corrected visual acuity
  - pupil reflexes
  - anterior segment examination **(OPR 6.1)**
  - tonometry
  - posterior segment examination **(OPR 6.2)**
- provide treatment options that include, as indicated:
  1. topical corticosteroids to reduce inflammation
  2. topical cycloplegics to relieve pain, prevent iris adhesion to the anterior lens capsule (synechiae), and prevent protein leakage from inflamed blood vessels (flare)
  3. topical non-steroidal anti-inflammatory drugs (NSAIDs) to reduce inflammation leading to macular edema that may accompany uveitis
  4. topical intraocular pressure (IOP) lowering medications to reduce elevated IOPs
  5. over-the-counter oral analgesics to reduce pain
- arrange follow-up every 1-7 days until resolution and then as deemed appropriate to monitor for recurrence
- counsel patients regarding the serious nature of uveitis, stress compliance with the therapeutic regimen and follow-up appointments, and discuss potential side effects of long term corticosteroid use
- recommend referral **(OPR 4.5)** when appropriate, including initiating communication with the patient's primary care physician or another health care provider for

evaluation and treatment if a systemic etiology is suspected (for example: when the condition is recurrent or bilateral, non-responsive to aggressive treatment, is accompanied by clinical signs or symptoms characteristic of systemic disease (including but not limited to: joint or lower back pain; respiratory, genitourinary or digestive difficulties; preceding or accompanying fever, malaise or skin rash) or involves the choroid as posterior uveitis), or when recalcitrant cases of uveitis require oral steroids or prescription analgesics where topical steroids or over-the-counter analgesics have produced little response

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OPR

OPTOMETRIC PRACTICE REFERENCE

CLINICAL GUIDELINES

COLLEGE OF Optometrists OF ONTARIO

The best eye health and vision for everyone in Ontario, through excellence in optometric care.

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COLLEGE OF
Optometrists
OF ONTARIO

PART 1. The Fundamentals

1. Introduction and Purpose

1.1 Introduction

The College of Optometrists of Ontario is the regulatory body for the optometric profession in Ontario. In order to assist the College in meeting its objects, documents relating to optometric practice are periodically developed and published. This Optometric Practice Reference (OPR) represents a complete revision of The Guide to the Practice of Optometry and supersedes previous versions of The Guide. It will be periodically updated in response to changes in public need, economic forces, advances in health care sciences, and statutory and regulatory requirements.

1.2 The Purpose of the Clinical Guidelines

- **To provide information to the public and patients** and/or their representatives regarding the services and behaviour that can be expected from a member of the College.
- **To promote ongoing discussion** and education among optometrists, ultimately leading to improvements in the quality of care and best practice for services provided to patients.

2. The Practice of Optometry

2.1 Scope of Practice

The *Optometry Act* specifies the scope of practice of optometry as follows:

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

a) disorders of refraction;

b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and

c) prescribed diseases.

2.2 Authorized Acts

The Province of Ontario uses the concept of *controlled acts* to describe healthcare procedures and responsibilities that are not within the domain of the public. This forms the basis for regulation of healthcare services in the province. Fourteen of these *acts* are described in the *Regulated Health Professions Act* and each profession-specific act, such as the *Optometry Act*, specifies those that are authorized to the professional group.

In the course of engaging in the practice of optometry, optometrists are authorized, subject to the terms, conditions and limitations imposed on their certificate of registration, to perform the following:

1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.

2. Applying a prescribed form of energy.

2.1 Prescribing drugs designated in the regulations.

3. Prescribing or dispensing for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

2.3 The Practice of Optometry

There are several key principles that form the foundation for the optometric profession. The practice of optometry is:

Professionally based

Above all, the purpose of the optometric profession is to provide for the healthcare needs of patients, by placing the patient's best interest foremost.

Scientifically based

The profession of optometry is founded on research and education in the life and vision sciences, combined with scientific and technological expertise.

The College supports the use of evidenced-based techniques, instrumentation and therapies that have the support of peer-reviewed literature.

Primary health care

Optometrists are independent practitioners who work within Ontario's healthcare system in co-operation with other providers of related services for the ultimate benefit of patients.

Related to eyes and vision

The services generally provided in primary care optometry include:

- the assessment, diagnosis, management and prevention of conditions of the eye and vision system;
- the treatment, correction or rehabilitation of conditions of the eye and vision system;
- the dispensing of eye glasses, contact lenses, and low vision devices;
- referral to, or shared care with, allied health professionals; and
- the promotion of good vision and health through education.

Accountable to the public

The practice of optometry in Ontario is governed by the College of Optometrists of Ontario under the authority of the Regulated Health Professions Act and the Optometry Act. Accountability is assured in a number of ways including public representation on Council and College committees, and open (public) Council meetings and Discipline hearings. In addition, the College publishes an Annual Report and provides annual reports to the Minister of Health and Long-Term Care.

2.4 The Practitioner/Patient Relationship

With reference to the practitioner/patient relationship, the optometrist will:

Be accountable

Optometrists are accountable to their individual patients and to the College for all services provided, both personally and by others who are under their direction and supervision.

Act in the patient's best interest

Optometrists are responsible for fostering a relationship of trust with the patient and putting the patient's interest above their own. The Professional Misconduct

Regulations protect such interests. Examples of acts that are considered to be professional misconduct include:

- treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence; **(O.Reg. 119.94 Part I under the Optometry Act (1. s.10))**
- failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination. **(O. Reg. 119/94 Part I under the Optometry Act (1. s.11))**

Encourage patient decision-making

Consistent with patient-centered care, optometrists give patients the information and counselling necessary for them to make informed choices about treatment and ongoing care, and respect the choices their patients make.

When employing techniques, instrumentation and/or therapies that lack the support of peer-reviewed literature, optometrists are expected to discuss the risks and benefits with the patient and obtain informed consent with documentation where appropriate.

Protect confidentiality

Historical and clinical information is gathered in a manner respecting patient privacy. All records are kept confidential and secure. Release of information requires the consent of the patient or their representative(s), except as required or allowed by law, such as the *Personal Health Information Protection Act*.

Be ethical

Optometrists' behaviour and business practices conform to the profession's accepted ethical standards. This is emphasized in the Professional Misconduct Regulation which includes the following as an act of professional misconduct:

- engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical. **(O. Reg. 119/94 Part I under the Optometry Act (1. s.39))**

Effective Date: April 2014

Revised: September 2014

3. Guidelines: Definitions

3.3 Clinical Guidelines

Guidelines are not mandatory; they are suggestions that will assist the prudent practitioner to reach the level of best practice. Guidelines evolve with current research and are shared through various professional publications and communications. While guidelines usually describe desirable practice, their application may be limited by the scope of practice allowed within a given jurisdiction.

Revised: April 2014

PART 2. Optometric Care

COLLEGE OF
Optometrists
OF ONTARIO

Effective Date: February 2015

4. General Clinical Matters

4.1 Clinical Equipment

Description

Optometrists are expected to be equipped with the instrumentation and supplies required to provide services that meet the standards of practice of the profession.

Clinical Guideline

Scientific and technological advances will bring changes to the equipment available. It is recommended that optometrists stay current with the new technology.

Last Reviewed: February 2018

First Published: September 2007
Revised: May 2009
April 2014
February 2015

4.2 Required Clinical Information

The provision of optometric care relies on acquiring, updating and maintaining a complement of information about each patient. Analysis of these data enables optometrists to develop an accurate understanding of the ocular status of patients and devise appropriate management plans. Standards relating to required clinical information are intended to ensure the provision of optimal and efficient patient care.

Clinical Guideline

At specific assessment, consultation or emergency visits, where patients have not been directly referred but report being under the established care of another optometrist or ophthalmologist, optometrists should request confirmation of the care provided by the other practitioner(s). In all situations, clear and timely communication between practitioners ensures that patient care is optimized while duplication of testing is minimized.

Optometrists may choose to employ ancillary procedures in addition to those required to obtain the normal complement of required clinical information in order to enhance or refine a clinical diagnosis or management plan. This is particularly true when the rapid pace of scientific and technological advancement in equipment and instrumentation is considered **(OPR 4.1)**. Examples of such procedures include, but are not limited to:

- fundus photography, optical coherence tomography, scanning laser ophthalmoscopy, and similar high-technology imaging/mapping systems;
- corneal topography;
- ophthalmic ultrasonography (A or B scan), ultrasound biomicroscopy;
- advanced refractive technologies (e.g. wavefront analysis, aberrometry, etc);
- visual electrophysiology (e.g. electroretinograms, visually evoked potentials, electro-oculograms).

While these procedures may contribute valuable information in the assessment of specific clinical presentations, optometrists are reminded that patients should not be required or coerced to undergo ancillary procedures. Prior informed consent is necessary.

First Published: September 2007

Revised: April 2012
April 2014
June 2014
June 2018

4.3 Delegation and Assignment

Introduction

The Province of Ontario utilizes the concept of "controlled acts" to control who may perform healthcare procedures and responsibilities that have a high risk of harm associated with their performance. The controlled acts are listed in the *Regulated Health Professions Act, 1991 (RHPA).* Each profession-specific act, such as the *Optometry Act, 1991*, specifies any controlled acts that the members of the profession are authorized to perform (the profession's "authorized acts"). Each regulated profession has a defined scope of practice and some have corresponding authorized acts set out in the profession-specific Act.

There are also numerous non-controlled procedures, some of which are limited to objective data collection and others, which carry a potential risk of harm to the patient. Although these procedures are in the public domain (i.e. they are NOT controlled acts), they may require specific training and skills.

The term *delegation* refers to the process whereby a regulated health professional (RHP), who has a controlled act within his/her scope of practice, orders another person who would not otherwise be authorized to do so to perform this act.

The term *assignment* refers to the process of an RHP assigning the performance of a non-controlled procedure to another person.

Both delegation and assignment of optometric procedures in appropriate circumstances may allow a more timely and efficient delivery of optometric care, making optimal use of time and personnel. In every instance of delegation and assignment, the primary consideration should be the best interests of the patient.

It is a general expectation that optometrists will be responsible for, and appropriately supervise all delegated and assigned activities within their practices. The level of supervision varies with the risk associated with the delegated or assigned procedure. ***Direct supervision*** refers to situations in which the optometrist is physically present in the same clinical location. This allows the optometrist to immediately intervene when necessary. Direct supervision is expected for ALL delegation (controlled acts), and of any assigned activities, which require interpretation in the performance of the procedure and/or may present a risk of harm to the patient. ***Remote supervision*** refers to situations in which the presence of the optometrist is not necessarily required since there is no potential risk of harm to the patient. This would be appropriate for certain clinical procedures and objective data collection.

The responsibility for all aspects of any delegated acts or assigned procedures always remains with the optometrist.

Optometrists may also *receive delegation* of a controlled act not authorized to optometry.

Guideline for Delegation by an Optometrist

The optometrist remains responsible for all activity within his/her office, including delegated and assigned procedures. It is prudent to always ensure that any activities being delegated or assigned are appropriately supervised and performed in a safe, effective and accurate manner.

Good communication skills for both the optometrist and staff members are essential for effective delivery of patient care, particularly when procedures are delegated or assigned. Formal courses in procedures and communication are very helpful to complement appropriate staff training. Regular staff training, assessment and an effective office policy and procedural manual are also helpful resources to promote competence.

It is also wise to ensure that the person performing the delegated or assigned procedure is clearly indicated within the patient health record. This is essential for both quality assurance and medico-legal reasons.

First Published: February 2005

Revised: May 2009
April 2014

4.4 The Use And Prescribing Of Drugs In Optometric Practice

Description

Optometrists use diagnostic and therapeutic drugs in the course of providing patient care. The College recognizes that there is a distinction between the use of drugs within a clinical setting and the prescribing of drugs for treatment. Optometrists with authority to prescribe drugs can do so to manage patients with diseases and disorders of the eye and vision system. Such drugs are usually topically applied eye drops or ointments and oral medications for corneal or eyelid infections only.

Clinical Guideline

Optometrists should be familiar with and adhere to accepted diagnostic and treatment considerations for diseases and disorders of the eye and vision system. Current literature and Clinical Practice Guidelines are helpful to guide diagnostic and therapeutic considerations.

Frequency of follow-up examinations

The frequency of follow-up examinations for conditions of the eye and vision system requiring treatment with drugs varies greatly. Optometrists should use sound clinical judgement to determine an appropriate schedule. Factors that should be considered include:

- the severity and morbidity of the condition;
- the potential adverse complications;
- the patient's systemic health considerations; and
- expected progress of therapy.

Emergency and After-hours care

Patients may require emergency or after-hours care if the condition is not responsive to therapy or if an unexpected response to treatment occurs. During usual working hours it would be appropriate to have patients contact the optometrist's office for instructions. Optometrists should ensure that office staff has appropriate training and direction on arranging care for emergency presentations.

Outside business hours, consideration could be given to:

- having an accessible emergency contact system, answering service or other after-hours communication modality;
- having formal arrangements with qualified practitioners to provide accessible after-hours consultation when the prescribing optometrist is not available; and
- directing patients to hospital emergency rooms when appropriate.

Additional references relevant to this topic are available on the American Optometric Association website **(www.aoa.org)**:

- CPG 5 Care of the Patient with Primary Angle Closure Glaucoma
- CPG 7 Care of the Patient with Anterior Uveitis
- CPG 9 Care of the Patient with Open Angle Glaucoma
- CPG 10 Care of the Patient with Ocular Surface Disorders
- CPG 11 Care of the Patient with Conjunctivitis

First published: April 2004 (The Guideline for the Use of Drugs by Optometrists)

Revised: April 2011 (The Use and Prescribing of Drugs in Optometric Practice)

April 2014

4.5 Referrals

Description

A referral is a request for consultation and/or the provision of treatment made to another regulated health professional when a patient requires care that exceeds the optometrist's scope of practice or ability.

Clinical Guideline

When a referral letter has been written, it is appropriate in most cases to send a copy to the patient's primary healthcare provider.

Many consultants have printed material that includes office policies. Making these available may be helpful to patients attending these appointments.

If the patient has a specific request regarding the choice of consultant, this request should be honoured where possible and/or appropriate.

Last Reviewed: February 2018

First Published: January 2007
Revised: April 2014
September 2014
June 2018

4.6 Ocular Urgencies and Emergencies

Description

Urgencies and emergencies represent potential threats to the ocular and/or systemic health and well being of patients if not dealt with appropriately. Accordingly, specific examinations are performed to provide prompt assistance, intervention, and/or action to limit potential sequelae.

Clinical Guideline

When a *referral* **(OPR 4.5)** to another health professional is required, optometrists are expected to attempt to arrange the most appropriate consultation available. In all cases, information concerning the nature of the urgency or emergency is expected to be communicated to the practitioner receiving the referral. Unless patients are sent to the local emergency department for care, urgent or emergency referral appointments usually require a greater degree of assurance that the appointment time and date are accurately communicated to patients, and that patients attend the appointments. In cases where it is not possible to confirm an appointment, referral to the local emergency department with a note stating the reason for referral, may be necessary. In addition, it is recommended that optometrists follow up with patients on the results of appointments.

Optometrists may establish an after-hours communication strategy to guide patients in need of urgent or emergency ocular care. This may be in the form of additional recorded phone messages or signs on the office door.

Additional references relevant to urgent and emergency care are available on the American Optometric Association website **(www.aoa.org)**:

- CPG 5 Care of the Patient with Primary Angle Closure Glaucoma
- CPG 7 Care of the Patient with Anterior Uveitis
- CPG 10 Care of the Patient with Ocular Surface Disorders
- CPG 11 Care of the Patient with Conjunctivitis
- CPG 13 Care of the Patient with Retinal Detachment and Peripheral Vitreoretinal Disease

First Published: September 2007

Revised: May 2009

February 2013

April 2014

4.7 Infection Control in the Optometric Office

Description

Within all health care facilities there is a risk of transmission of infectious agents. Standards demand that all health care workers must mitigate that risk by being educated and proactive in the area of infection control. Documents and guidelines on the topic of infection control are published and periodically updated by government agencies, health care groups and academic institutions. All optometrists must be cognizant of current information on infection control and take appropriate measures within their practices.

Clinical Guidelines

Optometrists should have specific Standard Operating Procedures (SOP) documented, applied and monitored that define routine practices and additional precautions for the prevention of transmission of infectious agents in an optometric office. All staff should be appropriately educated regarding the SOP.

An SOP should be developed for each office which details the:

1. techniques used to disinfect the office and control transmission of infectious agents
2. frequency of and specific responsibility for disinfection of the office and instrumentation
3. specification of the disinfection substances to be used
4. additional precautions for specific situations.(e.g. patients or staff with a possible contagion)
5. plans to monitor compliance with and efficacy of the recommended precautions

Health Canada uses the term Routine Precautions to describe the system of infection prevention recommended to prevent transmission of infections in health care settings.

Routine Precautions should be applied to all patients at all times, regardless of diagnosis or infectious status. The basics of Routine Precautions are:

- hand washing (hand hygiene);
- using personal protective equipment (e.g. gloves, gowns, disposable resuscitation devices or pocket masks) when handling blood, body substances, excretions and secretions;
- appropriate handling of patient care equipment and soiled linen;
- preventing needle stick/sharp injuries;
- environmental cleaning;
- appropriately handling of waste;
- adopting personal care strategies (e.g. immunization, stay home when you are sick); and
- covering one's mouth and possibly wearing a surgical mask when coughing or

sneezing.

The MOHLTC has a website specifically for Health Professionals where provincial infection control guidelines and health alerts, including the Ontario Health Pandemic Influenza Plan, may be accessed:.

- http://www.health.gov.on.ca/en/pro/

Hand-washing

Hands should be washed before and after every patient contact, with soap and warm water, for 15 – 30 seconds.

Hand sanitizers may be used if hand-washing with soap and water is unavailable or impractical.

Gloves

Gloves are not a substitute for hand washing and are not required for routine patient care activities in which contact is limited to a patient's intact skin.

Sterile gloves are used for surgical purposes, are individually wrapped and are not generally required for optometric purposes. Non-sterile single-use gloves are normally used in optometric offices.

Non-sterile, single use gloves should be worn for contact with blood, body fluids, secretions and excretions, mucous membranes, open skin lesions or exudative rash, for handling visibly soiled items, or if anyone involved inpatient care has open skin lesions that can pose a risk to patients or other care providers

Gloves should be put on immediately before the procedure and removed immediately after use, before touching any environmental surfaces.

Transmission Based Precautions

Transmission may occur through the air or by direct contact with environmental surfaces (professional equipment, office furniture, skin to skin). Considerations for transmission based precautions may include:

- optometric support staff can play a role in initial triage of patients who are suspected of having airborne-transmitted infectious disease.
- rescheduling patients with suspected airborne-transmitted infectious disease upon entry into office; infectious particles can remain in the room for long periods of time.
- installing air exchange systems venting outside the office; a step, which may help to reduce the number of airborne pathogens.
- developing guidelines for disinfection of environmental surfaces (see sample SOP)

Infectious Material Spills

Patients can attend an optometric office in various states of poor health and various spills may occur, for example, as minor as the bleeding of a small cut, or as significant as vomiting. Optometric support staff should employ all precautions in treating and cleaning up such spills by using as necessary proper gloves, masks,

gowns and disposing of contaminated materials such that no one else could come in contact with them.

Sterilization, Disinfection and Antisepsis

Sterilization

- defined as the destruction of all forms of microbial life including bacteria, viruses, spores and fungi; usually applied to situations where the epithelium has been breached and/or blood products and/or infectious tissues are involved. Sterilization may be accomplished by:
  - autoclave
  - 6% hydrogen peroxide x 30 mins
  - 2% gluteraldehyde x 10 hrs

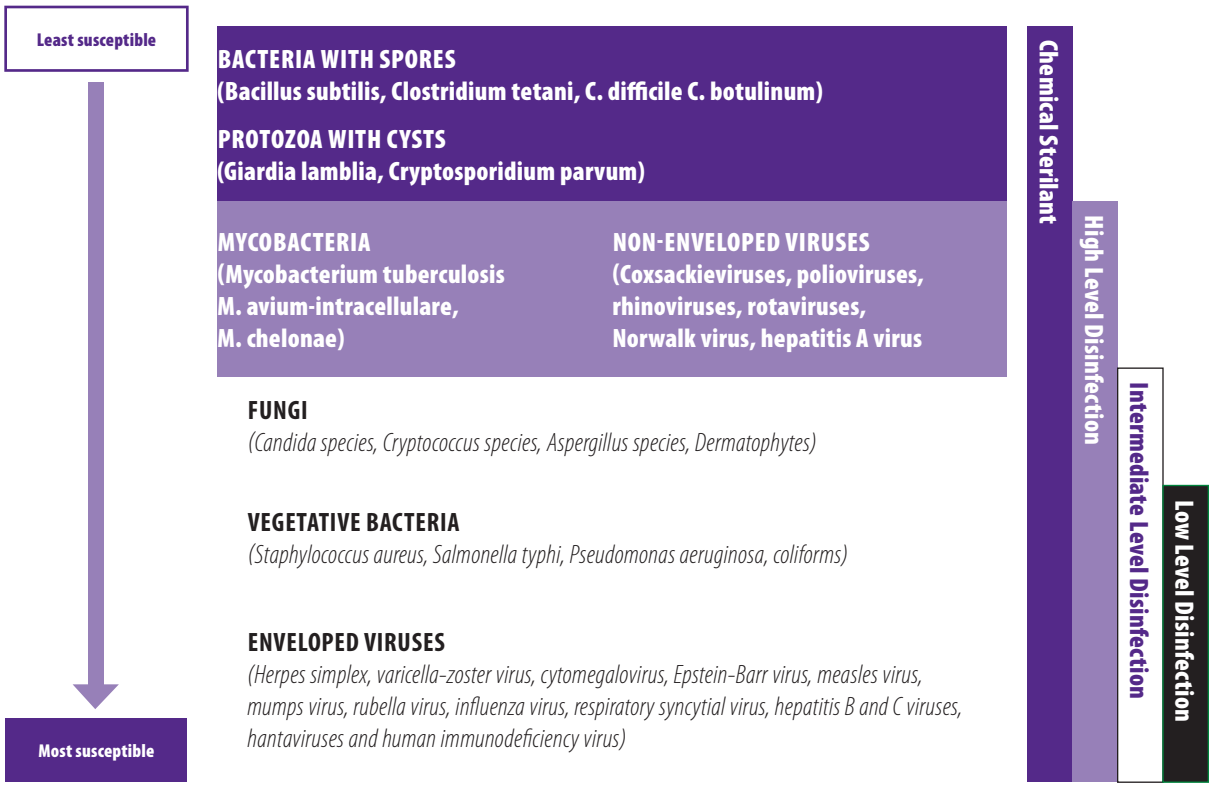
Disinfection (after disinfection, saline-rinse then air dry)

- high-Level Disinfection destroys vegetative bacteria, mycobacterium, fungi, enveloped (lipid) and non-enveloped (non-lipid) viruses **but it does not destroy bacterial spores**. It is accomplished by:
  - 2% gluteraldehyde x 20 mins
  - 1:50 dilution household bleach (hypochlorites) x 20 mins
  - 6% hydrogen peroxide x 10 mins
  - 7% AHP (accelerated hydrogen peroxide = Virox®) x 20 mins
  - 0.2% Peracetic acid x 30 – 40 mins
  - formaldehyde (37% formalin)
- intermediate-Level Disinfection does not destroy mycobacteria or enveloped viruses; it is accomplished by:
  - 1:100 dilution household bleach (hypochlorites) x 20 mins
  - 3% hydrogen peroxide x 10 mins
  - 0.5% AHP x 5 mins
  - 60-90% alcohol x 10 mins
  - iodophors (iodine or povidone-iodine)
- low-Level Disinfection destroys most vegetative bacteria and some fungi as well as enveloped (lipid) viruses **but does not destroy mycobacteria or bacterial spores.** It involves general housekeeping chores and is accomplished by:
  - QUAT (quaternary ammonium cation); multiple commercial types, i.e. Fantastik
  - phenoics (i.e. Lysol, Pine Sol)
  - 1:500 dilution household bleach

Antisepsis

- chemical agents intended for skin or tissue
  - isopropyl alcohol
  - chlorhexidine gluconate
  - iodophors (iodine or povidone-iodine)

Organisms & Recommended Level of Sterilization or Disinfection*



*Canada Communicable Disease Report
Infection Control Guidelines: Handwashing, Cleaning, Disinfection and Sterilization in Health Care, Health Canada Volume 24S8, December 1998

Assessing the Risk of Patient Contact

Situation	Infection Control Strategy (escalating)
Routine Patient Care No physical contact Communication with patients >1 metre away.	**Routine Precautions** Handwashing Respiratory etiquette (cover mouth/nose when coughing or sneezing, followed by proper handwashing)
Physical Contact with patients (intact skin)	**Contact Precautions** Handwashing
Physical contact with patients, where optometrist or patient has infected or open wound, non-intact skin, but no respiratory concerns	**Contact Precautions** Handwashing Gloves Proper removal and disposal of gloves followed by handwashing
Contact with patients, where procedure may involve body fluids, and/or droplets	**Droplet Precautions** Handwashing Use professional judgement (personal protective equipment (PPE)): Gloves Surgical Mask Eye protectors Gowns Proper removal and disposal of PPE followed by handwashing
Close contact with patients, respiratory symptoms	**Droplet Precautions** Handwashing Respiratory etiquette (cover mouth/nose when coughing or sneezing, followed by proper handwashing) Use professional judgement (PPE): Gloves Surgical mask for you and/or your patient Eye protectors
Close contact with patients, fever and respiratory symptoms	**Droplet Precautions** Handwashing Respiratory etiquette (cover mouth/nose when coughing or sneezing, followed by proper handwashing) Use professional judgement (PPE): Gloves Surgical mask for you and/ or your patient Eye protectors Follow health alerts if applicable
Contact with patients with known airborne infection e.g. active TB	**Airborne Precautions** Droplet Precautions with N95 mask Proper Ventilation
HEALTH ALERT IN EFFECT	**FOLLOW MOHLTC GUIDELINES**

Disinfectant Uses, Advantages and Disadvantages

Disinfectant	Uses	Advantages	Disadvantages
Alcohols	Intermediate level disinfectant Disinfect thermometers, external surfaces of some equipment Equipment used for home health care Used as a skin antiseptic	Fast acting No residue Non staining	Volatile Evaporation may diminish concentration May harden rubber or cause deterioration of glues Intoxicating
Chlorine	Intermediate level disinfectant Disinfect environmental surfaces Effective disinfectant following blood spills; aqueous solutions (5,000 ppm /1:10 bleach) used to decontaminate area After blood has been removed; sodium dichloroisocyanurate powder sprinkled directly on blood spills for decontamination and subsequent cleanup Equipment used for home health care Undiluted bleach can be used as a high level disinfectant	Low cost Fast acting Readily available in non hospital settings	Corrosive to metals Inactivated by organic material Irritant to skin and mucous membranes Use in well-ventilated areas Shelf life shortens when diluted (1:9 parts water)
Formaldehyde	Very limited use as chemisterilant Sometimes used to reprocess hemodialyzers Gaseous form used to decontaminate laboratory safety cabinets	Active in presence of organic materials	Carcinogenic Toxic Strong irritant Pungent odour
Gluteraldehydes	2% formulations – high level disinfection for heat sensitive equipment Most commonly used for spuds, lacrimal dilators, tweezers, Alger brush tips	Noncorrosive to metal Active in presence of organic material Compatible with lensed instruments Sterilization may be accomplished in 6 – 10 hours	Extremely irritating and toxic to skin and mucous membranes Shelf life shortens when diluted (effective for 14 – 30 days depending on formulation) High cost Monitor concentration in reusable solutions
Hydrogen peroxide	Low level disinfectant (3%) Equipment used for home health care Cleans floors, walls and furnishings High level disinfectant (6%) Disinfection of soft contact lenses, tonoprobes Higher concentrations used as chemisterilants in specially designed machines for decontamination of heat sensitive medical devices Stabilized hydrogen peroxide (0.5%) is used a high level surface disinfectant	Strong oxidant Fast acting Breaks down into water and oxygen	Can be corrosive to aluminum, copper, brass or zinc Surface active with limited ability to penetrate

Iodophors	Intermediate level disinfectant for some equipment (hydrotherapy tanks, thermometers) Low level disinfectant for hard surfaces and equipment that does not touch mucous membranes	Rapid action Relatively free of toxicity and irritancy	Note: Antiseptic iodophors are NOT suitable for use as hard surface disinfectant Corrosive to metal unless combined with inhibitors Disinfectant may burn tissue Inactivated by organic materials May stain fabrics and synthetic materials
Peracetic acid	High level disinfectant or sterilant for heat sensitive equipment Higher concentrations used as chemical sterilants in specially designed machines for decontamination of heat sensitive medical devices	Innocuous decomposition (water, oxygen, acetic acid, hydrogen peroxide) Rapid action at low temperature Active in presence of organic materials	Can be corrosive Unstable when diluted
Phenolics	Low/intermediate level disinfectants Clean floors, walls and furnishings Clean hard surfaces and equipment that does not touch mucous membranes	Leaves residual film on environmental surfaces Commercially available with added detergents to provide one-step cleaning and disinfecting	Do not use in baby nurseries Not recommended for use on food contact surfaces May be absorbed through skin or by rubber Some synthetic flooring may become sticky with repetitive use
Quaternary ammonium compounds	Low level disinfectant Clean floors, walls and furnishings Clean blood spills	Generally non-irritating to hands Usually have detergent properties	DO NOT use to disinfect instruments Non-corrosive Limited use as disinfectant because of narrow microbiocidal spectrum

Definitions

Antiseptics: chemicals that kill microorganisms on living skin or mucous membranes.

Bactericidal: chemical agents capable of killing bacteria. Similarly agents that are virucidal, fungicidal or sporicidal are agents capable of killing these organisms.

Bacteriostatic: chemical agents that inhibit the growth of bacteria but do not necessarily kill them.

Cleaning: the physical removal of foreign material, e.g., dust, soil, organic material such as blood, secretions, excretions and microorganisms. Cleaning generally removes rather than kills microorganisms. It is accomplished with water, detergents and mechanical action. The terms "decontamination" and "sanitation" may be used for this process in certain settings, e.g., central service or dietetics. Cleaning reduces or eliminates the reservoirs of potential pathogenic organisms.

Critical items: instruments and devices that enter sterile tissues, including the vascular system. Critical items present a high risk of infection if the item is contaminated with any microorganisms. Reprocessing critical items involves meticulous cleaning followed by sterilization.

Decontamination: the removal of disease-producing microorganisms to leave an item safe for further handling.

Disinfection: the inactivation of disease-producing microorganisms. Disinfection does not destroy bacterial spores. Disinfectants are used on inanimate objects in contrast to antiseptics, which are used on living tissue. Disinfection usually involves chemicals, heat or ultraviolet light. The nature of chemical disinfection varies with the type of product used.

High level disinfection: High level disinfection processes destroy vegetative bacteria, mycobacteria, fungi and enveloped (lipid) and non-enveloped (non lipid) viruses, but not necessarily bacterial spores. High level disinfectant chemicals (also called chemical sterilants) must be capable of sterilization when contact time is extended. Items must be thoroughly cleaned prior to high level disinfection.

Intermediate level disinfection: Intermediate level disinfectants kill vegetative bacteria, most viruses and most fungi but not resistant bacterial spores.

Low level disinfection: Low level disinfectants kill most vegetative bacteria and some fungi as well as enveloped (lipid) viruses (e.g., hepatitis B, C, hantavirus, and HIV). Low level disinfectants do not kill mycobacteria or bacterial spores. Low level disinfectants are typically used to clean environmental surfaces.

Noncritical items: those items that do not directly contact the patient, or come in contact with only intact skin but not mucous membranes. Reprocessing of noncritical items involves cleaning and/or low level disinfection.

Sanitation: a process that reduces microorganisms on an inanimate object to a level below that of infectious hazard (e.g., dishes and eating utensils are sanitized).

Semi-critical items: devices that come in contact with non-intact skin or mucous membranes but ordinarily do not penetrate them. Reprocessing semi-critical items involves meticulous cleaning followed preferably by high-level disinfection.

Sterilization: the destruction of all forms of microbial life including bacteria, viruses, spores and fungi. Items should be cleaned thoroughly before effective sterilization can take place.

References

1) Guidelines for Infection Preventions and Control in the Physician's Office. BC Centre for Disease Control 2004. **www.bccdc.ca**

2) A Guide to Selection & Use of Disinfectants. BC Centre for Disease Control 2003. **www.bccdc.ca**

3) Infection Control for Regulated Health Professionals. Federation of Health Regulatory Colleges of Ontario.

4) Spaulding's Classification. Cindy Wigston, Infection Prevention & Control Coordinator/Quality Leader, Orillia Soldier's Memorial Hospital.

5) Best Practices for Hand Hygiene In All Health Care Settings, Provincial infectious Diseases Advisory Committee (PIDAC), Ministry of Health and Long-Term Care, Published-May 2008, Revised-January 2009. **www.health.gov.on.ca/en**

6) Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/ Devices in all Health Care Settings, Provincial Infectious Diseases Advisory Committee (PIDAC), Ministry of Health and Long-Term Care, Published-April, 2006, Reviewed and revised February, 2010. **www.health.gov.on.ca/en**

First published: April 2011

Revised: February 2013
April 2014

SAMPLE Standard Operating Procedure

Levels of disinfection are commensurate with patient risk factors. When in doubt, use of high level disinfection is recommended

Areas for Disinfection	Area	Sub-Area	Device	Level of Disinfection	Freq.	Who	DA
	Professional	Exam Room (↑ disinfection commensurate with patient's infection)	Spuds, Alger Brush, Lacrimal Dilators, Cannulas	High	1	A	
			Tonometer/Pachimeter probes	Intermediate	1	A	
			Contact Lenses	Intermediate	1	A	
			Forehead/chin rests (phoropter, perimeter, OCT, camera, auto-tonometer/refractor	Low	1	A	
			Occluders, eye patches	Low	1	A	
			Diagnostic Equipment (i.e. perimeter, OCT)	Low	3	A	
			Sinks	Low	3	A	
			Exam Chair & Unit	Low	3	A	
			R/G Glasses	Low	2	A	
			Trial Frame	Low	2	A	
			Hand Held Instruments	Low	2	A	
		Lab/Dispensing Area	Contact Lens Cases	Intermediate	1	B	
			Frame warmer	Low	4	B	
			Frames on Display	Low	4	B	
			Frame Displays	Low	4	B	
			Lab hand tools	Low	3	B	
	Administrative	Desk Counters		Low	3	B	
		Computer Keyboards, Mouse & Telephone		Low	3	B	
		VISA Device		Low	3	B	
		Staplers, Tape Dispensers		Low	4	B	
		Pens, Pencils		Low	4	B	
		Fax Machines		Low	3	B	
	General Office	Waiting Area		Low	3	B	
		Toys		Low	2	B	
		Door Handles		Low	2	B	
		Washrooms		Low	2	B	
		Light Switches		Low	3	B	

Freq. Codes	
1	After direct patient contact
2	End of day
3	Weekly
4	Monthly

Who	
A	Individuals Directly involved in Patient Care
B	Designated Office Staff/Cleaning Staff

Disinfecting Agent (DA)	Level	Code
2% Glutaraldehyde	H	1
1:50 bleach	H	2
6% H_2O_2	H	3
Virox	H	4
1:100 bleach	I	5
3% H_2O_2	I	6
60 – 90% alcohol	I	7
Iodine/Povidine	I	8
Com. Cleaner	L	9

4.8 Collaboration and Shared Care

Description

The term "collaboration" has arisen to describe sharing of care between professionals. Such shared care is usually complementary. It has become apparent that professionals who provide complementary health care services to patients often will find ways to work together to co-manage/share care of patients. This is often beneficial to patients as it may allow better accessibility to the health care system, lower costs to the system and patients and allow more specialized practitioners to devote more time to their area of expertise.

Optometrists collaborate with many health care professionals including other optometrists, ophthalmologists, family physicians, other medical practitioners, nurse practitioners and opticians. This document describes the characteristics and conditions of collaboration as they apply to the profession of optometry.

Clinical Guideline

Although all health professionals are required to maintain the standards of practice set by their own profession, optometrists entering into formal collaborative relationships should take all necessary steps to ensure that the other professionals involved are competent to perform the necessary procedures and services. This could include:

- ensuring that formal qualifications and provincial licensure exist;
- jointly participating in training/education activities;
- developing a joint quality assurance process; and
- regularly reviewing and revising the collaborative agreement.

Conflict of Interest and Fee Issues

When health professionals collaborate, a potential for various conflicts of interest will develop. These include:

- inappropriate referrals (for example referral to your collaborating professional when another RHP would be more appropriate); and
- fee sharing and/or referral fees.

Optometrists should ensure that any potential conflicts of interest are minimized by ensuring that patients fully understand the roles, responsibilities and fees for each professional.

Responsibility

In a collaborative relationship, the professionals providing care share joint responsibility for the assessments and care provided. The formal collaborative agreement will outline this, but members should ensure that all parties involved have a complete understanding. Although the collaborative agreement would not necessarily be in writing, it should be verifiable to a third party if the question arose. It is expected that collaborating professionals will agree on a process for resolving patient problems. If any inconsistency or irregularity in clinical findings

and/or care arise, it is the responsibility of all the professionals involved to ensure that appropriate clinical investigations and treatments are performed, however the prescribing professional should take the leading role in these steps.

First published: May 2009

Revised: April 2014

5. Documentation

5.1 The Patient Record

Description

The Patient Record is comprised of two essential parts: the Patient Health Record, including all clinical documentation, and the Financial Record, summarizing diagnostic and treatment fees charged to and paid by the patient. The record is a legal document, with a purpose of meeting professional regulatory requirements, and shall be available for use in the following College processes: Inquiries Complaints and Reports, Discipline and Quality Assurance.

Clinical Guideline

Custodianship of the Patient Health Record

The delivery of quality health care benefits from access to historical clinical information. It is important that optometrists working in a multi-practitioner setting are clear on their rights, responsibilities, and obligations regarding the custodianship of patient health records.
With regard to custodianship of records, optometrists working together should obtain legal advice to develop a business agreement that articulates the rights, responsibilities, and obligations of each party in the event of a practice break-up.

In the absence of an existing business agreement, the College has adopted the following Guidelines for members:

- **Practice Owner**

The optometrist is the custodian of the record.

- **Partnerships**

When two or more optometrists carry on practice in a partnership, the partnership is the custodian of the records. If a partnership dissolves, all partners are equal custodians of all records.

- **Associates**

In the absence of an agreement, associates have no inherent right to have access to patient information, and the practitioner with primary responsibility for the records is not required to provide patient information to associates if they leave the practice. The practice and the owner(s) of the practice retain custodianship of the records, including clinical and contact information. The patient health record must only be released with the consent of the patient, or as required by law.

- **Cost Sharing Arrangements**

Where two (or more) members are in a cost sharing arrangement, both optometrists are the custodian of the records they made.

- **Optometry Professional Corporations**

If a practice is being conducted under an Optometry Professional Corporation, the corporation is the custodian of all the patient health records associated with the practice.

Electronic Records

Hardware and software provisions for data protection are often part of the manufacturer's purchase options. Such protection may vary as follows:

- the safety of the hardware from lightning strikes, hydro brownouts, water damage, theft;
- restriction to access through the use of passwords, the positioning of terminals to restrict the observation of sensitive data by unauthorized people (i.e. the data terminal at the front desk being seen by other patients standing there), and read-only format of data for the protection of its original content;
- a reliable backup through some form of secure off-premises data storage, which may be cloud-based;
- virus and spyware protection; and
- security of patient personal and financial information with any online transactions.

Optometrists should be diligent in maintaining current technology to protect the security of electronic patient data.

College of Optometrists of Ontario documents relevant to this topic are:
Records: Practice Breakup

http://collegeoptom.on.ca/images/pdfs/Records.pdf

Last Reviewed: February 2018

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Revised: June 2012
June 2014

5.2 The Prescription

Description

A prescription is a therapeutic directive between an optometrist and a patient. A prescription is based upon the analysis of all available clinical information and subsequent diagnoses from optometric examination. Optometrists may issue two distinct types of prescriptions: **optical prescriptions,** which when combined with further appliance-specific information, enable the patient to obtain eyeglasses, contact lenses or subnormal vision devices; and **prescriptions for drugs,** which specify topical or oral drugs used to treat certain ocular diseases.

Clinical Guideline

It may be advantageous for optometrists to include additional information on the prescription such as fax and email information and office hours.

Optometrists should consider retaining a copy of every issued prescription with the *patient health record* **(OPR 5.1).**

Optical Prescriptions:

Recommended Prescription Expiry for all Optical Prescriptions

Patient Age	Expiry
≤ 19	One year
20 to 64	Two years
≥ 65	One year

Spectacle Prescriptions

The spectacle prescription should include all items that are necessary for the preparation of the spectacles. The sphere, cylinder and axis are essential to most spectacle prescriptions. Other elements are essential in some cases: for example, reading addition, prismatic power, bicentric prism, or vertex distance of the refraction.

Appliance-Specific Prescriptions

Clinical justification should exist when a prescription contains appliance-specific information.

Contact Lens Prescriptions

The contact lens (appliance-specific) prescription should include those items necessary for the preparation of contact lenses. These may include lens type, base curve, diameter and power.

Prescriptions for drugs:

Clinical justification should exist when optometrists indicate "no substitutions" for a prescribed medication.

Prescription forms with pre-printed lists of medications should generally be avoided to reduce the possibility of alteration by patients.

Optometrists should consider using clear, modern language to avoid the potential for errors and misinterpretation often found with abbreviations and antiquated Latin abbreviations.

Optometrists should consider reporting medications prescribed for patients to their primary health care provider to enhance the provision and coordination of care.

They should also consider including, where appropriate, a printed recommendation to discard the unused portion of the medication once the treatment is completed.

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April 2015

6. General Procedures

6.1 Anterior Segment Examination

Description

The anterior segment can be considered as the front third of the eye, encompassing the structures in front of (that is, anterior to) the vitreous humour, including, the lids and lashes, conjunctiva and sclera, cornea, anterior chamber, iris, and crystalline lens. The anterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders and dysfunctions of the eye and vision system. Information obtained from an anterior segment examination is part of the *required clinical information* **(OPR 4.2)**.

Clinical Guideline

Gonioscopy, or use of reliable imaging technology, may be employed when a detailed assessment of the anterior chamber angle is required. Additional technologies and techniques are available for specialized assessment, including but not limited to corneal topography, wavefront analysis, specular microscopy, optical coherence tomography, and ultrasound biomicroscopy. Ophthalmic dyes and optical filters are often helpful in diagnosing diseases and disorders affecting the ocular surface.

Additional references relevant to this topic are available on the American Optometric Association website **(www.aoa.org)**:

- Care of the Patient with Primary Angle Closure Glaucoma (CPG 5)
- Care of the Patient with Anterior Uveitis (CPG 7)
- Care of the Patient with Open Angle Glaucoma (CPG 9)
- Care of the Patient with Ocular Surface Disorders (CPG 10)
- Care of the Patient with Conjunctivitis (CPG 11)
- Care of the Contact Lens Patient (CPG 19)

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April 2014

6.2 Posterior Segment Examination

6.2 Posterior Segment Examination

Description

The posterior segment can be considered as the back two-thirds of the eye, encompassing the structures behind (that is, posterior to) the crystalline lens, including the vitreous humour, optic nerve head and retina. The posterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders, and dysfunctions of the eye and visual system. Information obtained from a posterior segment examination is part of the *required clinical information*. **(OPR 4.2)**.

Examination Procedures

METHOD	CHARACTERISTICS
1 **Direct Ophthalmoscopy**	Maximum magnification Minimum field of view
2 **Binocular Indirect Ophthalmoscopy**	Maximal field of view Minimal magnification Scleral indentation view Minimal range of condensing lens, fixed objective lens
3 **Monocular Indirect Ophthalmoscopy**	Moderate field of view Moderate magnification
4 **Slit Lamp Biomicroscopy (slit lamp photography)**	High magnification and a very bright light source permit better appreciation of the optic nerve, macula, retinal vessels and other posterior pole structures.
5 **Fundus Photography**	Moderate field of view and magnification with a wide range of filters and recording media. Colour, black and white, film or digital recording.
6 **Imaging Technologies**	Include: • optical coherence tomography (OCT) • confocal scanning laser ophthalmoscopy (SLO) • scanning laser polarimetry (GDx) • multi-spectral imaging

Clinical Guideline

In general, patients should undergo a dilated fundus examination (DFE) upon their initial presentation to a practitioner. DFE should also be performed periodically thereafter as circumstances warrant.

The name and concentration of the dilating agent used and time of instillation should be recorded in the patient record. The procedure(s) used to examine the posterior segment should also be recorded.

Fundus photography and/or other reliable imaging technologies are becoming more common within optometric practice and are meant to complement, but not

to replace, the required elements of an oculo-visual assessment (ophthalmoscopy). In many situations they are of great clinical benefit. Practitioners should be familiar with, and be in the position to provide patients with, or refer patients for, such services when indicated.

Additional references relevant to urgent and emergency care are available on the American Optometric Association website **(www.aoa.org)**:

- Care of the Patient with Diabetes Mellitus (CPG 3)
- Care of the Patient with Age-Related Macular Degeneration (CPG 6)
- Care of the Patient with Open Angle Glaucoma (CPG 9)
- Care of the Patient with Retinal Detachment and Peripheral Vitreoretinal Disease (CPG 13)

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April 2014

Effective Date: September 2017

6.3 Refractive Assessment and Prescribing

Description

Assessing the patient's refractive error and, where required, *prescribing* **(OPR 5.2)** an optical correction is an integral part of optometric care. Assessment methods include objective and subjective techniques.

Clinical Guideline

Refraction Techniques

Refraction techniques fall into two broad categories. Objective techniques generally require no decision-making by the patient and include:

- retinoscopy
- auto-refraction
- wave-front assessment

Subjective techniques depend on responses from the patient and may include:

- trial frame methods
- phoroptor methods
- auto-refractor with subjective capability

New and advanced techniques for the assessment of the refractive status of the eye and vision system continue to be developed. It is recommended that optometrists maintain current knowledge of new technologies.

Prescribing for Subnormal Vision Devices, Contact Lenses or Eyeglasses

Although the objective and subjective refractive results are important in formulating a prescription for subnormal vision devices, contact lenses or eyeglasses, the prescription is the treatment of the refractive error. The optometrist should consider a number of other factors prior to issuing the prescription including:

- habitual correction;
- entering visual acuity;
- anticipated adaptation;
- patient preference;
- ocular health: A number of ocular health conditions, such as *cataract* formation **(OPR 7.3**), and ocular surface disease **(OPR 7.11)** may affect the refractive error. These may cause temporary or permanent refractive changes.
- systemic health: Some systemic health conditions may influence the refractive error by circulatory changes and/or osmotic balance of the eye and other parts of the vision system. A common example of this is *diabetes* **(OPR 7.4).**
- binocular vision: Binocular vision anomalies, such as accommodative, or convergence dysfunctions or anisometropia, may affect the final *prescription*. **(OPR 6.7)**

- occupational and avocational visual environment and demands: Many occupations or avocations have specific visual demands that require patients to view certain working distances on a regular basis or assume certain postures posing specific optical requirements. For example, a computer operator requires specific optical correction for viewing the computer monitor.

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September 2017

6.4 Spectacle Therapy

Description

Optometrists are authorized to dispense spectacles for the treatment of disorders of refraction and/or sensory and oculomotor disorders and dysfunctions of the eye and vision system. The patient must present a valid prescription written by an optometrist or physician.

Clinical Guideline

In order to advise patients of products appropriate for their specific needs, optometrists are encouraged to maintain up-to-date knowledge with respect to advances in optical products including, but not limited to, lens designs, spectacle lens materials, coatings, tints and frames. Consideration of additional factors may be made in special circumstances:

1. High Refractive Error:

- **a.** Lens materials with higher refractive indices and/or aspheric designs may be recommended for prescriptions indicating higher refractive error.
- **b.** A specific size or shape of frame may be selected to better support higher power prescription lenses.
- **c.** Additional specific measurements may be taken to ensure the effectiveness of the prescription (including but not limited to monocular interpupillary distances, pantascopic tilt, optical centre height and vertex distance).

2. Presbyopia:

- **a.** Determination of multifocal fitting height may require consideration of specific patient characteristics, such as stature, posture, vocation and avocation.
- **b.** A specific progressive-addition lens design may be recommended for an individual patient to reduce adaptation difficulties and/or maximize visual performance.
- **c.** Specialty multifocal lenses, including computer progressive-addition lenses, may be recommended for patients with extensive intermediate and near vision demands.
- **d.** Specialty vocational lenses may be considered where patients have unique or non-standard vision tasks.

3. Anisometropia:

- **a.** Special consideration should be given to the effect of base curve and thickness of lenses in affecting the patient's adaptation to and visual performance with spectacles. Manipulation of such parameters may be made to optimize the effectiveness of the prescription.

b. Special consideration should be given to vertical prismatic imbalance. Alternative lens designs, such as bicentric grind, may be recommended to the patient.

c. Special consideration should be given to cost and/or cosmetic appearance when choosing the power and optical parameters of a balance lens.

4. Accommodative and Binocular Vision Disorders: (OPR 6.7)

a. The multifocal style and height prescribed for young children may be altered from standard practices, to maximize the effectiveness of the prescription.

b. The use of high index lens materials and/or Fresnel prisms may be considered for prism prescriptions.

5. Low Vision Aids: (OPR 6.6)

a. Spectacle mounted low vision devices, including microscopes, telemicroscopes and telescopes may be provided.

b. The use of Fresnel prisms and lenses may be considered for special prescriptions.

c. A specific size or shape of frame may be selected to adequately support the low vision aid.

d. Adequate counselling and training in the use of the spectacles should be provided to the low vision patient.

6. Safety Requirements:

a. Occupational safety lenses and frames should meet Canadian Standards Association (CSA) Z94.3 standards.

b. Sports spectacles and goggles should meet CSA Z94.3 standards.

c. Impact resistant lenses should be utilized whenever possible. Special consideration should be given to the use of highly impact resistant materials (such as polycarbonate) for children and monocular patients.

7. Other:

a. Custom frames may be obtained for patients with special needs and/or facial deformities.

b. A ptosis crutch may be fitted to a spectacle frame to provide support for a ptotic eyelid.

Expired Prescriptions:

Optometrists providing spectacle therapy to patients with expired prescriptions should obtain the express (written) consent of patients.

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September 2014
October 2015

Spectacle Therapy using the Internet

Professional and Regulatory Standards Interpreted

Introduction

This document describes how optometrists may utilize their website and/or the internet in spectacle dispensing practices, while meeting the standards of practice of the profession. Ophthalmic dispensing is defined as "the preparation, adaptation and delivery" of vision correction, and is a controlled act in Ontario authorized to optometrists, physicians and opticians:

3. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

Standard of Practice for Spectacle Therapy

Section 6.4 Spectacle Therapy in the Optometric Practice Reference (OPR) describes the professional standards for spectacle therapy. Optometrists providing spectacle therapy must satisfy the following standards, regardless of whether or not technology is used as a tool to facilitate the provision of spectacle therapy to patients

- Reviewing with the patient any relevant environmental, occupational, avocational, and/or physical factors affecting spectacle wear;
- Reviewing the details of the prescription;
- Advising the patient regarding appropriate ophthalmic materials;
- Taking appropriate measurements (including but not limited to interpupillary distance and segment height) to ensure proper function of the spectacles;
- Arranging for the fabrication of the spectacles;
- Verifying the accuracy of the completed spectacles to ensure that they meet required tolerances;
- Fitting or adjusting the spectacles to the patient;
- Counselling the patient on aspects of spectacle wear including, but not limited to: the use, expectations, limitations, customary adaptation period and maintenance requirements of the spectacles.

Application of the Standard when providing Spectacle Therapy using the Internet

Reviewing factors affecting spectacle wear: Optometrists must review, with patients, factors affecting spectacle wear. This can be done either in-person, or by telephone, video conference, or online questionnaire. If this review is not performed in-person, optometrists should include a precaution for patients that in-person reviews are recommended for individuals with special needs or atypical facial and/or postural features. If optometrists choose specific patient factors by which to limit their internet dispensing services, including, but not limited to, a

specific age range, this should be disclosed on the website where patients can easily find it.

Reviewing the details of the prescription: Optometrists must review prescription details. This can be done in-person or using the internet. Optometrists are responsible for confirming the validity and/or veracity of prescriptions and must have a mechanism in place to do so. Prescriptions provided using the internet must be provided in a secure manner and collected in an unaltered form (pdf/image). All prescriptions must contain information that clearly identifies the prescriber (including name, address, telephone number and signature), and specifies the identity of the patient and the date prescribed **(OPR 5.2 The Prescription)**. All prescriptions must include an expiry date.

Advising the patient regarding appropriate ophthalmic materials: Optometrists must advise patients regarding appropriate ophthalmic materials. This may be done in-person or by an online algorithm. In the latter scenario, patients must be given clear directions on how to contact the office/optometrist with any questions they may have.

Taking appropriate measurements: Optometrists must take appropriate measurements when providing spectacle therapy. These can be done in-person or by computer application. If computer applications are used (in-office or remotely) to determine dispensing measurements, optometrists must be satisfied that the application determines these measurements with equal accuracy to traditional in-person measurements, including the production of supportable evidence should this matter come to the attention of the College.

Arranging for the fabrication of the spectacles: Optometrists must review the suitability of patient orders before arranging for the fabrication of spectacles.

Verifying the accuracy of the completed spectacles: Optometrists must verify the accuracy of completed spectacles.

Fitting or adjusting the spectacles to the patient: Fitting or adjusting the spectacles to patients must be performed in-office and cannot be performed virtually, by tutorial and/or video conferencing. Optometrists providing spectacle therapy will possess the equipment required to fit and adjust spectacles. In-person fitting and adjusting of spectacles provides a final verification and mitigates risk of harm by confirming that patients leave the clinic with spectacles that have been properly verified, fit and adjusted. In-person delivery of spectacles establishes a patient/practitioner relationship in circumstances where patients are new to the clinic and spectacle therapy was initiated through the optometrist's website.

Counseling the patient regarding spectacle wear: Counseling regarding spectacle wear is ongoing and involves in-office, telephone, and/or electronic communications.

Additional Considerations

Delegation: Optometrists who delegate elements of spectacle dispensing (for example, the fitting and adjusting of spectacles) to staff who are not authorized to independently perform the controlled act, must be present in the same physical location as their patient and able to intervene, unless another optometrist is present to provide appropriate delegation **(OPR 4.3 Delegation and Assignment)**.

Most Responsible Dispenser: In collaborative or multi-optometrist practices, where multiple optometrists may participate in dispensing spectacles to an individual patient, the College considers that the last optometrist to provide care, or "touch the patient", typically the optometrist fitting or adjusting the spectacles, is the most responsible dispenser. This optometrist is responsible for all preceding steps in the dispensing process, as well as the performance of the spectacles and any potential risk of harm to the patient. Similarly, where optometrists practice in working arrangements with opticians, the most responsible dispenser is the last professional to provide care to the patient.

Jurisdiction: OOntario-based optometrists providing care to patients in other jurisdictions (provinces/states) may need to be registered in those jurisdictions and should consult with the appropriate regulatory authorities. Optometrists participating in any aspect of ophthalmic dispensing in Ontario must be registered with the College of Optometrists of Ontario.

The Patient Record: Internet prescriptions and orders must be maintained in the patient record **(OPR 5.1 The Patient Record).**

Internet Sites: Where the internet is used in the provision of spectacle therapy, websites must:

- comply with College advertising guidelines and relevant paragraphs in the Professional Misconduct regulation **(O. Reg. 119/94, Part I under the Optometry Act)**;
- identify the website as belonging to or referring to a member registered with the College of Optometrists of Ontario;
- collect and record patient information in a private and secure manner respecting patient confidentiality;
- identify the physical location of the clinic/dispensary, including address and city/town, and the hours of operation of the clinic; and
- include the telephone number to contact the clinic/dispensary.

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6.5 Contact Lens Therapy

Description

Optometrists are authorized to prescribe and dispense contact lenses for the treatment of:

- disorders of refraction, and/or sensory and oculomotor dysfunctions of the eye and vision system, and/or
- diseases/disorders affecting ocular health, and/or
- anatomical, structural and/or cosmetic concerns

The provision of this service to patients involves an initial assessment to determine suitability of patients for contact lens therapy, a determination of the parameters of a contact lens appropriate for patients, and ongoing monitoring of the efficacy of treatment. Contact lenses are classified by Health Canada as a medical device, not a consumer commodity, and should be treated accordingly.

Clinical Guideline

Frequency

Patients using contact lenses generally require, at minimum, annual assessments. Frequent monitoring is particularly important for patients on a continuous wear schedule.

Consent

Optometrists should obtain informed consent from all patients electing to wear contact lenses.

Instrumentation

In addition to the normal complement of *required clinical equipment* **(OPR 4.1)**, the following may be helpful in contact lens practice:

- instrumentation for the verification of contact lens parameters; and
- instrumentation to assess corneal topography and thickness.

Special considerations

Patients using contact lenses require:

- more frequent follow-up examinations;
- counselling regarding the increased risk of potentially sight-threatening complications and precautionary measures for avoiding them; and
- appropriate instructions on how and when to access emergency care **(OPR 4.6)**.

Management of Adverse Outcomes

Although infrequent, adverse ocular complications may occur with contact lens wear. Treatment options may include:

- discontinuation of lens wear or modification of wearing schedule;
- modification of lens design, material or care system;
- appropriate ocular or systemic therapy; and/or
- *referral* **(OPR 4.5)** to another regulated health practitioner.

Optometrists should maintain current knowledge of contact lens therapy and are encouraged to consult peer-reviewed literature and professionally developed guidelines.

Additional references relevant to this topic are available on the American Optometric Association website **(www.aoa.org)**:

- Care of the Patient with Ocular Surface Disorders (CPG 10)
- Care of the Contact Lens Patient (CPG 19)

College of Optometrists of Ontario documents relevant to this topic are:

- Contact Lens Advisory: Contact Lenses – Questions and Answers

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April 2014
September 2014

6.6 Low Vision Assessment and Therapy

Description

Patients are considered visually impaired when best-corrected vision is inadequate for an individual's daily needs. These patients may benefit from a low vision evaluation. This includes extended evaluation of visual function, review of ocular health and systemic health conditions that may impact visual function, treatment with various optical and/or non-optical low vision aids and/or rehabilitation strategies directed towards specific needs and demands, as well as counselling and education.

The need for a low vision evaluation will generally be determined as the result of specific clinical findings from an optometric examination **(see OPR 4.2 - Required Clinical Information)**. Other possible reasons for conducting a specific low vision evaluation include referral from another practitioner or direct referral from a patient or family member. Repeat or ongoing examinations may be required to determine the response to treatment or to monitor the status of patients with low vision.

Clinical Guideline

Specialized Testing and Considerations

Several specialized or non-standard test procedures may be utilized in a low vision evaluation:

1. Visual acuity
    a. Distance visual acuity charts may include the Feinbloom, Bailey-Lovie, ETDRS and Lea Symbols charts
    b. Near visual acuity charts may include the Lighthouse, ETDRS and MN Read near acuity charts
    c. Specialized techniques, include preferential looking and visually evoked potentials,
    d. The effect on visual acuity of variations in viewing posture, illumination and test distance may be explored
2. Refraction
    a. Objective techniques such as radical retinoscopy, off-axis retinoscopy, and near retinoscopy
    b. Subjective techniques such as trial frame refraction, just-noticeable-difference technique, hand-held Jackson crossed cylinder, stenopaic slit, and multiple pinhole
    c. Refraction techniques may be performed at non-standard distances
3. Ocular Motility and Binocular Vision
    a. Specific testing for ocular motility and binocular vision may be done to evaluate these aspects of vision

   b. Low vision devices designed for monocular or binocular use, or for use in specific positions of gaze, according to binocular status

4. Visual fields
   a. Automated perimetry
   b. Goldmann perimetry
   c. Tangent Screen
   d. Amsler Grid
5. Supplemental tests
   a. Contrast sensitivity testing
   b. Glare testing
   c. Colour vision testing
   d. Electrodiagnostic testing: VEP, ERG, EOG
   e. Micro-perimetry

Management

Management of low vision and severe visual impairment may involve the use of optical aids, electronic and computerized devices and non-optical techniques and training.

Optical and Electronic aids

- spectacle lenses
- tints, filters, lens coatings
- hand magnifiers
- stand magnifiers
- microscopes
- telescopes
- telemicroscopes
- prisms
- mirrors
- reverse telescopes and minus lenses
- electronic devices

Complex optical devices may be prescribed, where indicated:

1. Spectacle mounted microscopes and telemicroscopes can enhance near vision
2. Spectacle mounted telescopes can enhance distance vision
3. Prisms, mirrors, reverse telescopes and minus lens systems may be used to expand peripheral visual fields
4. Biconvex aspheric lenses and achromatic doublets can reduce glare

5. Electronic devices such as CCTVs, adaptive computer hardware and software and head-mounted devices can be effective for vocational and educational needs
6. The use of lenses, prisms or occlusion can be designed for cases of nystagmus, strabismus, diplopia or substandard binocular vision

Low vision aids may be prescribed for binocular, biocular or monocular viewing.

Instructions and training for the proper use and maintenance of aids and devices is necessary.

Non-optical Aids and Devices

- Lighting, reading guides, large print materials, audio devices, etc.
- Rehabilitation services involves training the patient to adopt non-standard viewing practices such as:
    - eccentric viewing;
    - vertical or diagonal scanning;
    - blur interpretation; and
    - enhanced saccades and pursuits.

Additional Services

Patients with low vision often benefit from the assistance of other health professionals and accordingly a referral for additional services may be indicated including:

1. Orientation and mobility training
2. Occupational therapy
3. Social and community services
4. Counselling
5. Genetic counseling
6. Surgical consultation

Additional Information and Reference

Additional references relevant to this topic include:

Care of the Patient with Visual Impairment (Low Vision Rehabilitation)

Prepared by the American Optometric Association Consensus Panel on Care of the Patient with Low Vision, revised 2007:

http://www.aoa.org/documents/CPG-14.pdf

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Revised: April 2014

6.7 Binocular Vision Assessment and Therapy

Description

Binocular vision is defined as the ability to maintain visual focus on an object with both eyes, creating a single visual image. Optometrists diagnose and treat both congenital and acquired disorders of binocular vision. Clinically, binocular vision is assessed within an optometric examination **(see OPR 4.2 - Required Clinical Information)** through investigation of the oculomotor and sensory systems.

Clinical Guideline

The scope of a binocular vision assessment/investigation will depend upon the clinical findings of the initial optometric exam. Many binocular conditions require only an initial diagnosis, followed by periodic re-assessment to ensure stability. Other conditions will require ongoing assessment to monitor changes or treatment progress.

Patient History

The patient history may include any or all of the following:

- visual demands of the patient;
- presence or absence of signs or symptoms related to binocular vision dysfunction and their impact on daily activities, including the use of validated questionnaires, when possible;
- a family history of binocular disorders;
- pre and perinatal risk factors;
- history of trauma or exposure to toxins;
- previous medical, ocular or surgical treatments;
- general medical status;
- learning abilities;
- gross and fine motor skills; and
- needs, goals and expectations of the patient (and their family, if applicable).

Testing Distances and Comitancy

At a minimum, a baseline binocular vision assessment includes distance and nearpoint testing in primary gaze. Consideration should be given to the evaluation of the binocular status at various additional test distances and positions of gaze.

Instrumentation and Techniques

A variety of instruments and techniques may be used for binocular vision evaluation and treatment, including:

- phoropters;
- ophthalmic lenses and prisms;
- polarized and anaglyphic filter instruments including computer based methods;
- various methods to assess comitance, retinal correspondence and the nature of monocular fixation (centred vs. eccentric), often involving the use of after images,

entoptic phenomena, and/or comparison of objective vs. subjective measures of the angle of deviation.

Assessment of Binocular Vision Disorders

Non-Strabismic Disorders

The characteristics of symptomatic orthophorias or abnormal heterophorias, including:

- magnitude and direction of phoria;
- accommodative amplitude, facility and response;
- vergence amplitude and facility;
- fixation disparity and/or associated phoria(s);
- any associated sensory disorders or adaptations.

Ocular Motility Disorders

Non-comitant deviations and nystagmus should be fully described and, where possible, underlying causes determined. Any abnormal sensory or postural adaptations should be documented.

Strabismic Disorders

When strabismus is identified, optometrists should investigate and describe the following for various test distances and positions of gaze:

- magnitude;
- direction;
- frequency;
- laterality; and
- associated sensory disorders or adaptations.

Analysis and Treatment

An analysis of the clinical findings of a binocular vision assessment should include a description or diagnosis and may also include consideration of:

- ocular or systemic disease;
- risk of development of amblyopia;
- if known, the etiology of the binocular vision disorder (congenital or acquired);
- refractive error;
- learning abilities;
- patient needs;
- realistic prognosis; and
- referral (if indicated).

Patients with binocular vision disorders vary significantly in their presentations, so each treatment plan should be individualized in consideration of patients' needs and resources.

The treatment plan may include optometric treatment of binocular vision disorders using lenses, prisms and/or vision therapy.

Optometrists should provide counseling with respect to:

- treatment options;
- realistic prognosis; and
- expected duration of treatment and associated costs.

Referrals for Strabismus Surgery

Optometrists referring patients for strabismus surgery should provide counseling with respect to risks and benefits.

Patient Counselling

Counselling enables patients to make informed decisions about their status and treatment options. Counselling is based upon an appropriate case history, clinical examination and analysis of visual demands.

Presurgical counselling should include, but is not limited to:

- general information including a description of the procedure, expected range of outcomes, normal healing course, and expected postoperative care schedule and procedures;
- benefits[1-4] including potential improvement in:
    - psychosocial well-being as a result of improved appearance;
    - gross stereopsis; and
    - binocular visual field;
- potential risks[2-7] including:
    - possible surgical and healing complications;
    - over or under correction;
    - iatrogenic diplopia;
    - potential need for repeated surgeries; and
    - persistent subnormal binocular vision;
- potential need for perioperative vision, refractive and/or prism therapy;
- provider options such as available surgical facilities and surgeons, as well as those qualified to provide preoperative and/or postoperative care;
- practitioner responsibilities so patients are informed of who will provide each aspect of their care; and
- details of any referral **(OPR 4.5)** to a strabismus surgeon.

Additional references relevant to this topic include:
American Optometric Association **(www.aoa.org)** Clinical Guidelines:

- CPG-4–Care of the Patient with Amblyopia
- CPG-12–Care of the Patient with Strabismus
- CPG-18–Care of the Patient with Accommodation and Vergence Dysfunction

1. Olitsky SE, Sudesh S, Graziano A, et al. The negative psychosocial impact of strabismus in adults. J AAPOS. 1999;3:209-11.

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6.8 Visual Field Assessment

Description

Optometrists may perform an assessment of the field of vision as part of an evaluation of the oculo-visual system. Assessment strategies used may be either screening or detailed (threshold) in nature, utilizing manual or computerized instruments and can be done to assess patients' central and/or peripheral field of vision. Visual field assessment is used in the diagnosis and monitoring of conditions of the eye and vision system including, but not limited to, glaucoma, neurological and retinal disease, and to fulfil third party reporting requirements. Information obtained from visual field assessment and analysis is part of the patient health record (OPR 5.1) and must be retained.

Clinical Guideline

Macular conditions

Testing of the central visual field is useful in assessing the status and progression of macular pathologies. Self-monitoring using an Amsler grid is often advisable. Threshold testing can also be performed if quantification of abnormalities is desired.

Glaucoma

Early detection of glaucoma may be facilitated by the use of alternative perimetric strategies, including but not limited to frequency doubling technology (FDT). However, threshold perimetry of the central 24 to 30 degrees is usually indicated for the diagnosis and ongoing management of glaucoma. Serial testing to monitor for progression is an integral part of glaucoma diagnosis and management. Patients deemed clinically stable usually require visual field assessment at least once a year. In advanced glaucoma, visual field defects encroaching upon fixation may be monitored through more frequent and detailed central analyses (for example, central 10-degree testing strategies).

Peripheral Field Assessment

Peripheral field assessment may be indicated to:

- fulfil third party reporting requirements;
- evaluate unexplained visual symptoms;
- assess some peripheral retinal pathologies;
- assess neurological conditions.

Kinetic perimetry

Kinetic perimetry is often useful for patients when static methods prove inadequate.

Computerized perimeters will typically archive results; however, optometrists should ensure that effective back-up methods are being utilized and/or hard copies are retained in the patient health record **(OPR 5.1)**.

Additional references relevant to this topic are:

American Optometric Association Clinical Practice Guidelines **(www.aoa.org)**:

- Care of the Patient with Primary Angle Closure Glaucoma (CPG 5)
- Care of the Patient with Open Angle Glaucoma (CPG 9)

First Published: June 2007

Revised: June 2014

7. Specific Diseases, Disorders and Procedures

7.1 Patients with Age-related Macular Degeneration

Description

Age-related Macular Degeneration (AMD) is an acquired retinal disorder that affects central visual function. Nonexudative AMD, also known as "dry" AMD, results in a gradual, progressive loss of central visual functioning, whereas patients with exudative AMD, also known as "wet" AMD, notice a more profound and rapid decrease in central visual functioning.

Clinical Guideline

For patients with macular degeneration examination with a fundus contact lens is useful in assessing the presence of macular edema. The use of advanced techniques to assess macular structure (for example, serial photography and/or optical coherence tomography (OCT)) and/or macular function (for example, microperimetry) may also be helpful in establishing a diagnosis, and/or monitoring disease progression and/or response to treatment.

Some patients may be candidates for low vision rehabilitation including the use of specialized optical devices and training. These patients may benefit from a consultation with a practitioner who has advanced training or clinical experience in low vision. When extensive visual loss occurs, optometrists should also consider referral for rehabilitation, occupational, vocational and independent living counselling services.

Management of patients with AMD may also include:

- home Amsler grid testing;
- education regarding current and emerging treatment options; and/or
- risk counselling for relatives.

Research in the area of macular degeneration is advancing quickly and it is recommended that members stay current with new diagnostic and treatment strategies as they become available.

Additional references relevant to this topic include:

Care of the Patient with Age-Related Macular Degeneration (CPG 6), American Optometric Association **(www.aoa.org).**

Preferred Practice Pattern - Age-Related Macular Degeneration, American Academy of Ophthalmology **(www.aao.org)**.

First Published: September 2006
Revised: February 2013
April 2014

7.2 Patients with Glaucoma

Description

Glaucoma* is a clinical term referring to a spectrum of conditions resulting in damage to the optic nerve and progressive reduction in sensitivity within the field of vision. Patients with glaucoma or patients with significant risks of having glaucoma (hereafter referred to as "glaucoma suspects" for consistency with current professional literature) are commonly encountered in optometric practice. Early diagnosis and therapy may reduce the rate of progression of this disease.

When glaucoma develops without an identifiable cause, it is termed primary.1 Primary open angle glaucoma is the most common form of this disease and may be managed by optometrists with therapeutic qualifications. Glaucoma with an identifiable cause is termed secondary.

Clinical Guideline

Glaucoma Examination

The need for and extent of a glaucoma investigation will generally be determined by the identification of patient specific risk factors and/or as the result of specific clinical findings from an optometric examination. Other indications for conducting a glaucoma examination include referral from another practitioner or assessment of a patient currently being treated for the condition. Multiple examinations may be required to confirm a diagnosis or monitor patients at risk of developing glaucoma.

Frequency

The frequency of glaucoma examinations depends upon the patient's clinical presentation, risk factors and the optometrist's professional judgment. Recommendations from accepted clinical guidelines1,2 and current professional literature should be used as a guide. For example, the Canadian Ophthalmological Society (COS)2 has the following recommendations;

Recommended clinical assessment intervals for stable chronic glaucomas.		
Glaucoma Suspects	1 or 2 of the following: • IOP > 21 mm Hg • suspicious disc or cup to disc (C/D) asymmetry of > 0.2 • suspicious 24-2 (or similar) VF defect	1 – 2 Years
Early Glaucoma	Early glaucomatous disc features (e.g. C/D* < 0.65) and/or mild VF defect not within 10 degrees of fixation (e.g. MD better than -6 dB on HVF 24-2)	At least every 12 months
Moderate Glaucoma	Moderate glaucomatous disc features (e.g. vertical C/D* 0.7–0.85) and/or moderate VF defect not within 10 degrees of fixation (e.g. MD from -6 to -12 dB on HVF 24-2)	At least every 6 months
Advanced Glaucoma	Advanced glaucomatous disc features (e.g. C/D* > 0.9) and/or VF defect within 10 degrees of fixation** (e.g. MD worse than -12 dB on HVF 24-2)	At least every 4 months

Evaluation of Patients with Glaucoma or Glaucoma Suspects

Generally, a comprehensive glaucoma evaluation would include consideration of the following:

1. History

- family history of glaucoma
- demographics, including race, age, sex
- medical status and history, including medications, and
- ocular history, including refractive error and previous corneal surgery and/or trauma.

2. Measurement of Intraocular Pressure

Intraocular pressure should be measured using a reliable, calibrated and disinfected instrument. At this time, the Goldmann applanation tonometer is commonly used and appears to be the most precise when compared to other methods[2].

Consideration should be given to recording relevant factors, such as:

- the effect of pupillary dilation
- time of day and diurnal variations
- additional significant clinical features, such as blepharospasm
- previous corneal surgery,
- existing corneal disease, scarring or dystrophy
- high corneal toricity
- instrument used

3. Evaluation of the Optic Nerve

The optic nerve head should be examined stereoscopically when possible, using a technique that provides sufficient resolution and magnification to accurately assess the following:

- cup/disc ratio
- colour
- depth of cupping
- visibility of lamina cribrosa
- neuroretinal rim appearance
- presence of peripapillary atrophy
- overall size of disc
- presence of disc hemorrhages

This evaluation will generally require pupillary dilation.

4. Analysis of the Visual Field

The visual field should be measured using an instrument that has thresholding capabilities. Frequency of testing is individualized for each patient and is based

on risk factors and previous findings **(OPR 6.8)**.

5. Evaluation of the Anterior Segment and Angle
The anterior segment should be evaluated initially and periodically as indicated for risk factors such as pseudoexfoliation, pigment dispersion, iris transillumination defects, and narrow or anomalous anterior chamber angles. Biomicroscopy and gonioscopy are generally the preferred methods of examination.

6. Measurement of the Corneal Thickness (Pachymetry)
Corneal thickness is an independent risk factor for the development of glaucoma[4]. Corneal thickness should be measured using a reliable, calibrated and disinfected instrument and recorded.

Risk factors are assessed at subsequent visits as clinically indicated.

Additional Considerations

1. Specialized Visual Field Testing and Analysis
Specialized forms of visual field testing, such as frequency doubling or blue-yellow perimetry, may be useful in detecting visual field loss at an earlier stage. Analysis software programs may also be helpful, particularly in identifying and assessing changes in the visual fields over time.

2. Imaging of the Optic Nerve and/or the Nerve Fiber Layer
Imaging and computer-assisted evaluation of the optic nerve and nerve fiber layer may aid in early diagnosis, analysis of progression and management of glaucoma. Examples include fundus photography, optical coherence tomography (e.g. OCT), confocal scanning laser ophthalmoscopy (e.g. HRT), and laser polarimetry (e.g. GDx).

3. Exploration of other influential factors, such as blood pressure, cardiovascular health, high myopia, migraines, blood transfusions.

Treatment

General considerations

The therapeutic management of primary open angle glaucoma[2] is within the scope of practice of optometrists with therapeutic qualifications **(OPR 4.4)**. The treatment should adhere to accepted clinical guidelines and current literature. Comprehensive guidelines are available from: the Canadian Ophthalmological Society[2], the American Optometric Association[1], American Academy of Ophthalmology[7] and the European Glaucoma Society[8]. Consideration should be given to:

- severity and rate of progression of the disease
- pre-treatment intraocular pressure and diurnal influence
- target intraocular pressure
- barriers to compliance and appropriate administration of treatment (i.e. dexterity, cognition, finances)
- the age and systemic health status of the patient
- known drug sensitivities, allergies or interactions

Collaboration and Shared Care (OPR 4.8)

There will be situations where the patient's best interests are served by a collaborative relationship between the optometrist and other consultants (i.e. another optometrist, physician, pharmacist, etc). The recording of information exchanged among all parties in a collaborative care relationship is crucial. Each party, including the patient, should understand the responsibilities and expectations in the collaborative relationship.

Drug Therapy

Open Angle Glaucoma

- treatment considerations for patients with glaucoma are constantly evolving. It is beyond the scope of this guideline to discuss all considerations; however treatment must be based on current clinical guidelines and research. The table below outlines the major classes, examples, generic names, indications and contraindications of glaucoma medications:

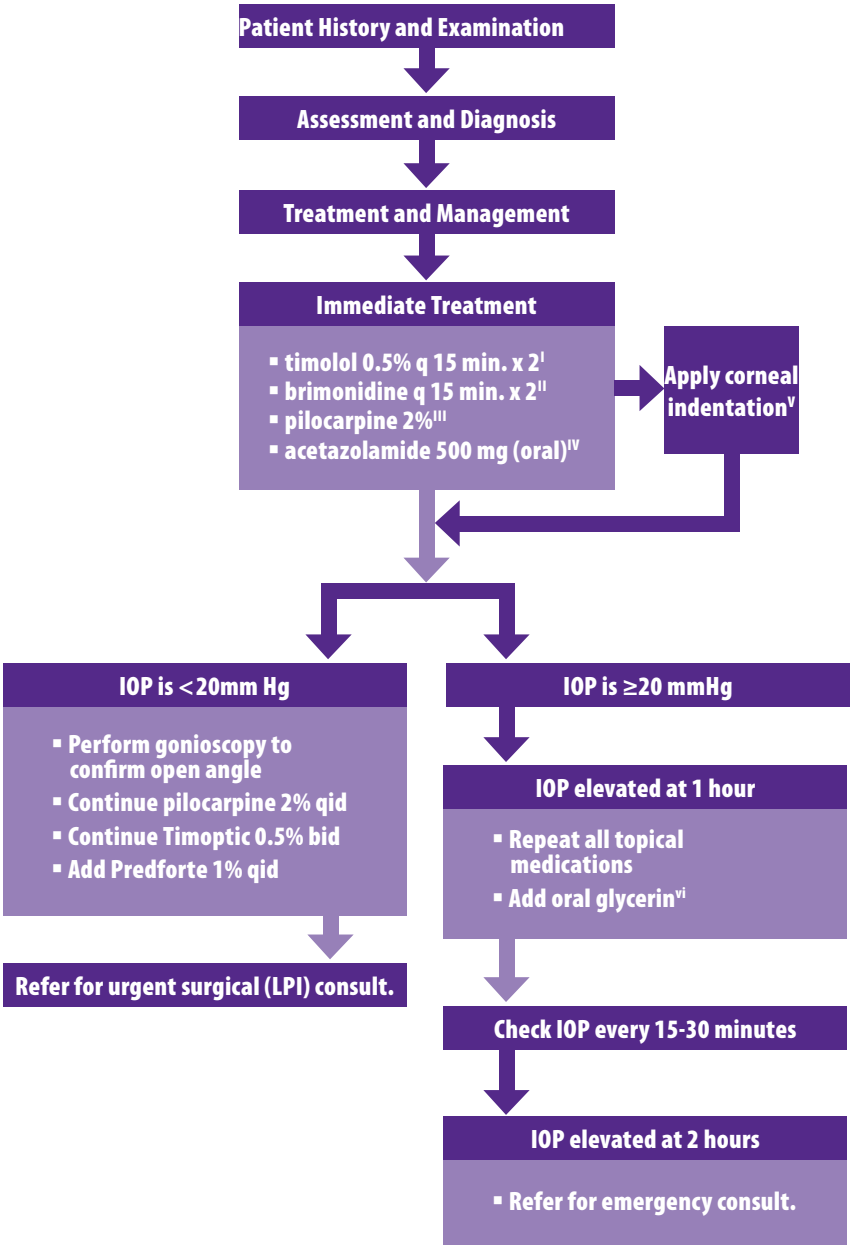
Anti-Glaucoma Medication	Trade Name	Generic Name	Conc.(%)	Indications	Contraindications [2]
Miotics	Isopto-Carpine (& Pilopine HS 4% Gel)	pilocarpine	1, 2, 4	Primary/ Chronic Open Angle Glaucoma (POAG/COAG) Angle Closure Glaucoma (ACG)	Miosis, RD, ocular inflammation, neovascular glaucoma, cataracts
	Carbachol	carbachol	1.5, 3		
Adrenergic Agonists	Iopidine	apraclonidine	0.5		Known sensitivity to any component
	Alphagan P	brimonidine	0.1, 0.15		
Beta-Blockers	Timoptic & XE	timolol maleate	0.25, 0.5		COPD, bradycardia, tachyphylaxis
	Betagan	levobunolol	0.25, 0.5		
	Betoptic S	betaxolol	0.25		
CAI's	Trusopt	dorzolamide	2		Sulfa allergies, Sickle cell disease, renal stones, aplastic anemia
	Azopt	brinzolamide	1		
	Diamox[1]	acetazolamide	250, 500 mg		
	Neptazane[1]	methazolamide	25, 50 mg		
Prostaglandins	Xalatan	latanoprost	0.005		Known sensitivity to any component, ocular inflammation
	Travatan	travoprost	0.004		
	Lumigan	bimatoprost	0.03, 0.01		
	Saflutan	tafluprost	0.015		
Combos	Combigan	brimonidine + timolol			As above
	DuoTrav	travoprost + timolol			
	Xalacom	latanoprost + timolol			
	Cosopt	dorzolamide + timolol			
	Azarga	brinzolamide + timolol			

1 Oral glaucoma agents for emergency treatment of angle closure glaucoma only.
2 Only significant contraindications are shown on the table. Consult formal drug information for complete listings. Some contraindications are absolute and others are relative. Members must use clinical judgment to assess the risk/benefit of using a drug when a contraindication is present.

Angle Closure

- An attack of angle closure is an ocular emergency. A timely referral to a physician or hospital must be made. When it is in the patient's best interest, optometrists should initiate emergency treatment for these patients within their clinical practices using appropriate therapy.
- The following Primary Angle Closure Glaucoma Treatment Flow Chart describes a general management plan of a patient with acute angle closure glaucoma in such an emergency situation.

Primary AC Treatment Flow Chart



Notes:

* All treatment is topical unless otherwise indicated.

i Use betaxolol 0.25% if patient has COPD.

ii Alternatively, apraclonidine 1% could be used

iii Use every 15 – 60 minutes up to a total of 2 – 4 doses; if IOP is > 40mm Hg, iris sphincter muscle may be ischemic, so Pilocarpine may not cause miosis until IOP is reduced below this level by other drugs.

iv Use two 250 mg tablets; avoid if patient has sulpha allergy; if patient has a kidney condition, use 100 mg Neptazane; if nauseated; consider IV Diamox. (if hospitalization available)

v Corneal Indentation in the Early Management of Acute Angle Closure; K. Masselos, A. Bank, I. Francis, F. Stapelton; August 12, 2008

vi Dosage 1.5 ml/kg body weight; serve over ice; if nauseated, consider IV Mannitol (if hospitalization available).

References and Additional Information

Additional references relevant to this topic include:

1. American Optometric Association Clinical Practice Guidelines
   Care of the Patient with Open Angle Glaucoma
   Care of the Patient with Angle Closure Glaucoma
   (http://www.aoa.org/x4813.xml)
2. Canadian Ophthalmological Society Evidence Based Clinical Practice Guidelines for the Management of Glaucoma in Adult Eyes.
   Can J of Ophthalmol – Vol. 44, Suppl. I, 2009
3. College of Optometrists of Ontario: Guideline for the Use of Drugs by Optometrists **(OPR 4.4)**
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   http://www.nei.nih.gov/glaucomaeyedrops/
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   August 12, 2008.
6. The Canadian Glaucoma Strategy (Draft): R.P. LeBlanc CM, MD, FRCSC, Department of Ophthalmology and Visual Sciences, Dalhousie University, Halifax N.S.
7. American Academy of Ophthalmology : Preferred Practice Pattern: Primary Open Angle Glaucoma Suspect. 2005; San Francisco **http://www.aao.org/**
8. Terminology and guidelines for Glaucoma: European Glaucoma Society.

For Standards of Practice click here

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PRACTICE GUIDELINES

Eye Health Council of Ontario Guidelines for the Care of Patients with Glaucoma

In April 2011, following years (indeed, decades) of effort by provincial and national associations, regulators, and practitioners, optometrists in Ontario saw the promulgation of Ontario Regulation 112/11, the Designated Drugs and Standards of Practice Regulation. This landmark legislation allowed optometrists to prescribe topical and oral medications for the treatment of eye disease, and obligated them to do so competently.

To that end, the Eye Health Council of Ontario (EHCO), following the successful development of the Guidelines for the Collaborative Management of Persons with Diabetes Mellitus by Eye Care Professionals (*Canadian Journal of Optometry* 2011;73(4):26-35), turned its attention to articulating similar guidelines for the management of persons with glaucoma.

These guidelines built upon the Canadian Ophthalmological Society's Evidence-based Clinical Practice Guidelines for the Management of Glaucoma in the Adult Eye (*Can J Ophthalmol* 2009;44(supp1):S1-S54) while recognizing the legislated authority for Ontario optometrists to independently manage patients with primary open-angle glaucoma. Over nearly two years of development and scrutiny by academic and practicing optometrists and ophthalmologists, the guidelines were drafted, debated, revised, rewritten, further debated, and eventually agreed upon.

With greater scope comes greater responsibility, and to that end, EHCO presents the Eye Health Council of Ontario Guidelines for the Care of Patients with Glaucoma.

Background

This document was developed in order to better define models of care for glaucoma suspects and patients with glaucoma in Ontario, given the change in the scope of optometric practice as outlined in Ontario Regulations 111/11 and 112/11, made under the Optometry Act (1994).

There is great variability in the severity and presentation of patients with glaucoma, making it difficult to articulate general guidelines for care applicable to all possible clinical presentations. The ultimate goal of the Guidelines is to increase accessibility and to improve the quality of care provided to these patients.

This Guideline referred to the Canadian Ophthalmological Society Evidence-based Clinical Practice Guidelines for the Management of Glaucoma in the Adult Eye (*Can J Ophthalmol.* 2009;44 (supp 1):S1-S54) for general principles and definitions, and the College of Optometrist of Ontario's "Standards of Practice – Glaucoma" and "The Designated Drugs and Standards of Practice Regulation". The Guideline is not intended to restrict scopes of practice or serve as a standard of medical care. Standards of medical care are specific to all the facts or circumstances in an individualized case, and can be subject to change as scientific knowledge and technology advance and as practice patterns evolve.

Principles of Interprofessional Collaboration

The Eye Health Council of Ontario endorses the Key Principles for interprofessional collaboration as outlined by the "Model of Interprofessional Collaboration in the Care of Glaucoma Patients and Glaucoma Suspects" (*Can J Ophthalmol* 2009;44(supp 1):S1-S54).

The key principles are:
- Patient-centred approach
- Timely access to appropriate eye care professional
- Ongoing commitment to high-quality standards of care
- Evidence-based approach to care
- Collegial relationships
- Effective, clear and timely communication
- Optimal utilization of professional competencies and finite resources
- Duplication of tests and services kept to a minimum

Regulations and Recommendations

Recommendations are presented in context with current optometry regulations in Ontario. These are recommendations only and need to be adapted to the individual circumstances of the clinical presentation, availability of eye care professionals, and resources.

A typical examination for a patient with glaucoma or a glaucoma suspect would include gonioscopy, intraocular pressure (IOP), central corneal thickness, threshold visual fields, and assessment and documentation of the optic nerve and nerve fibre layer. The current "standard" for measuring IOP is Goldmann applanation tonometry.

The accompanying table defines the stages of glaucoma.

Glaucoma Suspects

Optometry Regulation: The Regulation does not address patients considered glaucoma suspects.

STAGING OF THE GLAUCOMA SUSPECT AND PATIENTS WITH GLAUCOMA#

Suspect	1 or 2 of the following: • IOP > 21 mm Hg • suspicious disc or cup to disc (C/D) asymmetry of > 0.2 • suspicious 24-2 (or similar) VF defect
Early Glaucoma	Early glaucomatous disc features (e.g. C/D* < 0.65) and/or mild VF defect not within 10 degrees of fixation (e.g. MD better than -6 dB on HVF 24-2)
Moderate Glaucoma	Moderate glaucomatous disc features (e.g. vertical C/D* 0.7–0.85) and/or moderate VF defect not within 10 degrees of fixation (e.g. MD from -6 to -12 dB on HVF 24-2)
Advanced Glaucoma	Advanced glaucomatous disc features (e.g. C/D* > 0.9) and/or VF defect within 10 degrees of fixation** (e.g. MD worse than -12 dB on HVF 24-2)

HVF=Humphrey Visual Field Analyzer; MD=mean deviation

* Refers to vertical C/D ratio in an average size nerve. If the nerve is small, then a smaller C/D ratio may still be significant; conversely, a large nerve may have a large vertical C/D ratio and still be within normal limits.

** Also consider baseline 10-2 VF (or similar)

\# **Source:** Adapted from the Canadian Ophthalmological Society Evidence-based Clinical Practice Guidelines for the Management of Glaucoma in the Adult Eye. *Can J Ophthalmol.* 2009;44 (supp 1):S1-S54.

Low Risk Glaucoma Suspects

Glaucoma suspects of low risk may be managed by either an optometrist or ophthalmologist. Low risk glaucoma suspects have one of the following:
- IOP > 21 mm Hg
- suspicious disc or cup to disc (C/D) asymmetry of > 0.2
- suspicious 24-2 (or similar) VF defect (*Can J Ophthalmol.* 2009;44 (supp 1):S1-S54)

However the level of suspicion given these abnormal parameters is low enough that the health care professional has determined that it is unlikely the patient will develop glaucoma.

Low risk glaucoma suspects may include:
- Young adult patient with family history but no significant ocular findings
- Ocular hypertensive with pressures in the low- to mid-20s but no other significant ocular findings
- Patients with an anomalous or suspicious disc but no other significant ocular findings

After completion of the initial assessment and the establishment of baseline clinical data, the frequency of follow-up examinations will be left to the discretion of the attending eye care professional, although it is suggested that the patient should be followed at least every two years. At each follow-up visit, stability should be assessed (*i.e.* are the IOP, optic disc and visual field stable?). In cases where a change in optic disc or visual field is suspected, a confirmatory exam should be performed. If change is confirmed, then the patient should be managed as a patient with early glaucoma.

High Risk Glaucoma Suspects

Glaucoma suspects of high risk may be managed by either an optometrist or ophthalmologist, and should be assessed at least annually. High risk glaucoma suspects have one or more of the following, but the variation from the normal is much greater than that seen in low risk suspects:

- IOP > 21 mm Hg
- suspicious disc or cup to disc (C/D) asymmetry of > 0.2
- suspicious 24-2 (or similar) VF defect (*Can J Ophthalmol*. 2009;44 (supp 1):S1-S54)

High risk glaucoma suspects may include:

- IOP in the high 20s and a positive primary family history of glaucoma, but no other significant ocular findings
- Suspicious cupping, thin central corneal thickness, IOP in the low 20s but no other significant ocular findings

A high risk glaucoma suspect requires more frequent evaluations and/or testing following the establishment of baseline clinical data. Patients should be made aware of their risk factors for developing glaucoma, and the rationale to initiate ocular hypotensive therapy should be discussed.

Patients with Primary Open Angle Glaucoma

Optometry Regulation:

Optometrists "… may only treat a patient with glaucoma where the patient has primary open-angle glaucoma the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment."

In addition, "It is a standard of practice of the profession that a member may only treat a patient having open-angle glaucoma, the treatment of which is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment, in collaboration with a physician with whom the member has established a co-management model of care for that patient and who is:

(a) certified by the Royal College of Physicians and Surgeons of Canada as a specialist in ophthalmology; or

(b) formally recognized in writing by the College of Physicians and Surgeons of Ontario as a specialist in ophthalmology."

Patients with Early POAG

Patients with early POAG may be diagnosed and managed by either an optometrist or ophthalmologist. Careful baseline data should be established. Follow-up examinations should be at least every 6 months over the following 18 months in order to begin establishing the rate of progression. In general, stable patients should have an IOP assessment at least every 6 months, with visual field and objective optic nerve head assessment at least annually, depending on the clinical presentation.

Patients with Moderate POAG

Patients with moderate POAG may be diagnosed and managed by either an optometrist or ophthalmologist. However, optometrists are encouraged to refer the patient to an ophthalmologist immediately should they have any unresolved concerns over the patient's status. Alternatively, they may consider initiating treatment and referring the patient within a reasonable period of time (for example, 6 months) for consideration of future shared management. Following the establishment of sound baseline data, patients with a stable clinical presentation should have an IOP assessment at least every 6 months, with visual field and objective optic nerve head assessment at least annually, depending upon the clinical presentation. Should a patient with moderate POAG being managed by an optometrist demonstrate disease progression despite optimal medical therapy, the patient should be referred to an ophthalmologist.

Patient with Advanced POAG

Patients with advanced POAG are at significant risk of going blind and should be treated by the most experienced eye care professional available. In light of the frequent need for surgical intervention, an ophthalmologist with expertise in the surgical management of this disease should be responsible for the care of these patients. Should all treatment options be exhausted, a quiet end-stage eye may be more appropriately followed in a shared management arrangement.

IOP, visual fields and objective optic nerve assessment should occur at least every 3 to 6 months until the patient is considered stable. Patients with severe disease are at high risk of visual disability and blindness and should generally be treated more aggressively and followed at more frequent intervals

than those with earlier disease.

The clinical management of these patients should focus on ensuring stability of the IOP, visual field and optic nerve, adherence to treatment, and tolerance to medications.

Glaucoma Progression

Detecting, and ideally preventing, progression is key to the management of glaucoma.

The following are clinical scenarios of unstable glaucoma patients, taken from the COS Guidelines:

i. **IOP criterion:** If a patient on glaucoma treatment is not meeting target IOP despite changes being made in their medical management.
ii. **Visual field criterion:** If a patient on glaucoma treatment demonstrates repeatable, clinically significant and greater than expected change in the visual field, despite changes being made to their target IOP and medical management.
iii. **Optic nerve criterion:** If a patient on glaucoma treatment demonstrates repeatable, clinically significant and greater than expected change in the appearance of the RNFL or the optic nerve (for example, disc hemorrhage), despite changes being made to their target IOP and medical management.

The COS Glaucoma Guidelines recommend that a correlation between structural and functional changes be sought in suspected progression, even though it is more common for a change to be detected with one or the other independently. At all times, the variability of test results, both for structural and functional assessments, should be kept in mind, along with the existence of both false positive and false negative results.

Shared Management

The **Optometry Regulation** requires an optometrist to share management with an ophthalmologist for:

(a) POAG complicated by a concurrent medical condition, *or*
(b) POAG complicated by a potentially interacting pharmacological treatment.

In such circumstances there must be clear and documented communication outlining the expectations with respect to disease management, frequency of visits to each eye care professional and criteria for fast-track referral. It is important that the patient understands which clinician is the primary point of contact. This will normally be the optometrist, unless agreed upon by the optometrist and ophthalmologist and communicated to the patient. Repetition of tests should be minimized wherever possible.

Concurrent medical or ocular conditions of note may include but are not limited to:

- If a beta blocker is to be considered: these agents may be contraindicated if there is a history of congestive heart failure, bradycardia, heart block, asthma, chronic obstructive pulmonary disease or poorly controlled diabetes.
- If a prostaglandin is to be considered: these agents may be contraindicated if there is intraocular inflammatory disease or a history of cystoid macular edema (CME).
- If a cholinergic is to be considered: these agents may be contraindicated if there is intraocular inflammatory disease, retinal lattice degeneration, retinal tears or retinal detachment.

Potentially interacting pharmacological treatments of note may include:

- If a cholinergic is to be considered: these agents may interact with MAO inhibitors.

Note: the above bullets are not intended to be a comprehensive list in any way.

Recommendations for Shared Management:

- The results of all tests should be communicated between optometrist and ophthalmologist
  - *This could be as simple as stating: fields stable, no change in RNFL or ONH, IOP 14/15*
- All changes in management should be communicated between optometrist and ophthalmologist
  - *This could include changes in treatment, frequency of visits, and frequency of testing*
- All changes in advice to the patient should be communicated between optometrist and ophthalmologist
  - *This could include timing of medications, and use of punctal occlusion*

- Any changes in disease status or complications should be communicated between optometrist and ophthalmologist
  - *This could include disease progression, allergic reactions, significant side effects, and development of concurrent disease which may complicate test results (e.g. AMD, cataract)*

Secondary Glaucoma

Optometry Regulation:

"It is a standard of practice of the profession that a member (optometrist) shall immediately refer a patient having a form of glaucoma other than primary open angle glaucoma to a physician or to a hospital."

Recommendation:

Under these circumstances, following the initial referral there should be communication between the ophthalmologist and optometrist with respect to the diagnosis and ongoing management of the patient. The ophthalmologist may assume care of the patient, may recommend active shared management, or may offer to see the patient on an as needed (consultant) basis, specifying that the optometrist continues to provide primary care.

For example, a patient presents with pigment dispersion syndrome, suspicious cupping with a C/D ratio of 0.7, a repeatable nasal step defect, and IOPs of 25mmHg. The optometrist diagnoses the secondary glaucoma, and immediately arranges a referral to an ophthalmologist. The diagnosis is confirmed and a management strategy is developed. At that time, the ophthalmologist may elect to continue caring for the patient, may recommend a shared care paradigm, or may return the patient to the optometrist for continued care while remaining available on an as needed basis. A second possibility involves the optometrist calling the ophthalmologist, and the two agreeing upon an initial therapeutic approach until the ophthalmologist is able to review the patient.

Angle Closure Glaucoma

Optometry Regulation:

"(1) Subject to subsections (2) and (3), it is a standard of practice of the profession that a member (optometrist) shall immediately refer a patient having a form of glaucoma other than primary open angle glaucoma to a physician or to a hospital.

(2) It is a standard of practice of the profession that a member may initiate treatment for a patient having angle-closure glaucoma only in an emergency and where no physician is available to treat the patient.

(3) It is a standard of practice of the profession that a member shall immediately refer any patient being treated in accordance with subsection (2) to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

(4) In this section, "hospital" means a hospital within the meaning of the Public Hospitals Act."

Recommendation:

i. Angle Closure Suspect and Narrow Angles[1]: An optometrist may monitor narrow angles in patients at risk of eventually developing Angle Closure and/or Angle Closure Glaucoma. The optometrist should refer the patient to an ophthalmologist for consideration of prophylactic iridotomies should there be a risk of the angle becoming occludable.

ii. Primary Angle Closure: The optometrist should refer the patient to an ophthalmologist.

iii. Primary Angle Closure Glaucoma: The optometrist should refer the patient to an ophthalmologist.

iv. Acute Angle Closure: An attack of Angle Closure Glaucoma is an ocular emergency. A timely referral to a physician or hospital must be made. When it is in the patient's best interest, optometrists

[1] Definitions provided in: Angle Closure and Angle Closure Glaucoma. WGA Consensus Series 3. Eds: R.N. Weinreb & D.S. Friedman. Kugler Publications. 2006

Narrow Angles: Open but can close under appropriate circumstances; unable to view posterior trabecular meshwork (270°); IOP not elevated.

Primary Angle Closure Suspect: Narrow angles, verified by gonioscopy; no peripheral anterior synechiae; IOP not elevated; no evidence of disease (disc or field).

Primary Angle Closure: Shallow anterior chamber angle in presence of iridotrabecular contact, verified by gonioscopy; peripheral anterior synechiae; elevated IOP; no evidence of disc or field damage.

Primary Angle Closure Glaucoma: Shallow anterior chamber angle in presence of iridotrabecular contact, verified by gonioscopy; peripheral anterior synechiae; elevated IOP; evidence of disc and/or field damage.

should initiate emergency treatment for these patients within their clinical practices using appropriate therapy.[2]

For an optometrist and ophthalmologist to share the management of patients with Angle Closure and Angle Closure Glaucoma, following treatment by the ophthalmologist, there needs to be clear and documented communication outlining the expectations with respect to disease management, frequency of visits to each eye care professional and criteria for fast-track referral. It is important that the patient understands which clinician is the primary point of contact. This will normally be the optometrist, unless agreed upon by the optometrist and ophthalmologist and communicated to the patient. Repetition of tests should be minimized wherever possible.

Conclusions

The legal landscape of glaucoma care in Ontario has changed significantly with the recently expanded scope of practice for optometrists. The glaucoma suspect and patients with primary open angle glaucoma may be independently managed by optometrists. In addition, the amount of shared management between optometrists and ophthalmologists will increase. A patient-centred strategy, with particular attention to the patient's needs, coupled with frequent and clear communication between patient and practitioner, and between optometrist and ophthalmologist will result in optimum outcomes for patients.

The goal of these Guidelines is to propose a practical, patient-centered approach to the new regulations introduced for optometry. The aim is to maximize the accessibility, quality and safety of care for the patient within the Ontario health care environment, providing them with state of the art glaucoma care. At the same time, the recommendations in this document are meant to minimize duplication of effort and to utilize the available resources appropriately, with a view of achieving a cost-effective model of care for these patients.

La version française de cet article suivra dans le numéro 3.

[2] Optometric Practice Reference. College of Optometrists of Ontario.

7.3 Patients with Cataract

Description

The practice of optometry includes the diagnosis, care and, when appropriate, referral of patients with cataract. Optometrists also work in collaborative arrangements **(OPR 4.8)** providing preoperative and postoperative care to patients requiring cataract surgery.

Clinical Guideline

Optometrists should maintain current knowledge about cataract surgery in order to have a general discussion with the patient about treatment options.

Diagnosis

When diagnosing cataract, the patient history will be helpful and may include symptoms such as blurred vision, increased glare and haloes. Refractive shift may be a clinical indication of cataract. Ocular health investigation, including *anterior segment examination* **(OPR 6.1)** and *posterior segment examination* **(OPR 6.2)** with pupillary dilation, will aid diagnosis and guide treatment options.

Patient Counselling

Counselling enables patients to make informed decisions about their status and treatment options. Counselling is based upon an appropriate case history, clinical examination and analysis of visual demands. Optometrists provide patient-centered care that is respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions.

Presurgical counselling should include, but is not limited to:

- general information including a description of the procedure, expected outcomes, normal healing course, and expected postoperative care schedule and procedures;
- benefits including potential improvement in visual acuity;
- potential risks including possible surgical and healing complications, changes in optical quality and potential adaptation problems associated with postsurgical status;
- provider options such as available surgical facilities and surgeons, as well as those qualified to provide preoperative and/or postoperative care;
- practitioner responsibilities so patients are informed of who will provide each aspect of their care; and
- details of any *referral* **(OPR 4.5)** to a cataract surgeon.

Counseling may also include additional information such as A-scan technologies, intraocular lens (IOL) options and associated refractive surgical procedures.

If a referral for surgical treatment is indicated, optometrists should ensure appropriate informed consent is obtained.

Postoperative Care Considerations

Optometrists often provide continuing care of patients following cataract surgery and may tailor the continuing care regimen to the needs of the individual patient.

A typical examination schedule for an asymptomatic patient after uncomplicated surgery may be as follows:

- first day following surgery;
- one week following surgery;
- one month following surgery; and
- thereafter as required.

During follow-up care, the following procedures are typically performed:

- measurement of visual acuity;
- measurement of intraocular pressure; and
- slit-lamp biomicroscopy.

The ocular fundus is typically examined with pupillary dilation at one to three months following surgery. This may be necessary sooner if adverse symptoms arise. A stable refraction can generally be obtained at 4-6 weeks following surgery.

Other Considerations

- any unusual findings or complications should prompt optometrists to adjust their examination schedules and consider consulting with the surgeon about the management of the patient.
- optometrists should arrange for emergency care for any urgent or emergent complications that arise.
- optometrists should ensure that the patient understands how to access emergency care.
- the surgeon will generally provide required pharmaceuticals and/or prescriptions, as well as a schedule for medication use for an uneventful postoperative course. It is advisable to review this schedule with the patient at the postoperative visits in order to ensure proper understanding and compliance with the appropriate regime.
- some portions of the peri-operative care and services associated with cataract surgery may not qualify as insured services under the Ontario Health Insurance Plan and therefore optometrists may charge for these services. The fees are to be established by the individual optometrist, not by the surgical center or any third party. Optometrists should ensure that patients are fully informed of the details of the services and any associated fees.

Reminder Regarding Conflicts of Interest

Optometrists who accept rebates or receive other indirect remuneration or benefits as a result of surgical referral are at risk of allegations of professional misconduct.

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September 2017

7.4 Patients with Diabetes

Description

Diabetes mellitus (DM) is a very common systemic condition that can have numerous ocular manifestations. While diabetic retinopathy poses the greatest long-term threat to vision for most patients with diabetes, optometrists should also be alert to the development of many other possible complications ranging from transient fluctuations in refractive error and dysfunctions of accommodation and colour vision, to abnormalities in the cornea, iris, lens, vitreous, and optic nerve. Also, oculomotor anomalies may arise from neuropathies affecting the third, fourth, or sixth cranial nerves.

Clinical Guideline

Quality care of patients with diabetes starts with a meticulous and comprehensive case history. The patient history should elicit any visual symptoms such as blurred, distorted, or fluctuating vision, diplopia, flashes/floaters, etc., particularly if they are of recent onset. (Note that a recent onset of such symptoms in patients who deny a previous diagnosis of diabetes may arouse a suspicion of undiagnosed DM and trigger a referral **(OPR 4.5)** to a physician for appropriate medical testing).

Medical histories should be explored to determine the type and duration of the DM, and management regimes should be reviewed, noting:

- any oral medications taken;
- insulin type and usual dosage, where applicable;
- frequency and usual results of blood glucose self-monitoring; and/or
- recent laboratory values for HbA1c (if available).

This information provides valuable insight into patient compliance with therapeutic regimens and control of the DM, which may affect the development of ocular complications. It is also useful to determine if any history of non-ocular complications of DM such as neuropathy or nephropathy exists. The name of primary care providers should be noted in the record to facilitate communication and coordination of patient care.

In addition to the normal complement of *required clinical information* **(OPR 4.2)** to be obtained on each patient, certain supplementary procedures may be useful in some cases, depending on clinical findings. Such procedures may include:

- blood pressure measurement;
- colour vision assessment;
- contrast sensitivity testing;
- assessment of the anterior chamber angle (through gonioscopy or other clinically acceptable technique);
- fundus photodocumentation; and/or
- macular optical coherence tomography.

The presence of any of the following findings should lead optometrists to refer their patients to an ophthalmologist (preferably a fellowship-trained retinal specialist):

- severe non-proliferative diabetic retinopathy (NPDR):
- any proliferative diabetic retinopathy (PDR);
- clinically significant macular edema (CSME);
- neovascularization of the iris (NVI); or
- any unexplained vision loss.

Members should consult The Guidelines for the **Collaborative Management of Persons with Diabetes Mellitus by Eye Care Professionals**, as developed by the Eye Health Council of Ontario, for further guidance regarding referrals. **(Appendix 1)**

Loss of Vision

In spite of the treatment interventions available, some patients with diabetes will inevitably experience a permanent loss of visual acuity or functional vision. These patients may benefit from a specialized low vision consultation in which various optical or non-optical aids or other devices may be considered to assist with the independent performance of routine daily tasks. In addition, referral for orientation and mobility training, occupational/vocational consultation, or psychosocial counselling may help some patients to achieve more fulfilling, self-sustaining lifestyles.

Coordination of Care

In view of the multidisciplinary nature of diabetes management, appropriately documented communication with primary care providers and/or other members of the diabetes management team is important for the proper coordination of patient care. Patients should be encouraged to maintain contact with their primary care provider on a regular basis.

Additional references relevant to this topic include:

American Optometric Association **(www.aoa.org)** Clinical Practice Guidelines:
• Care of the Patient with Diabetes Mellitus (CPG 3)

First Published: January 2007

Revised: June 2012

April 2014

June 2015

Guidelines for the Collaborative Management of Persons with Diabetes Mellitus by Eye Care Professionals

EYE HEALTH COUNCIL OF ONTARIO
SEPTEMBER 23RD, 2011

Background

Diabetes is a disease that is growing rapidly in both incidence and prevalence in Ontario (dramatically exceeding the global estimates of the World Health Organization), and poses a major public health challenge on many fronts. [1] More specifically, diabetic retinopathy is the most common cause of new cases of legal blindness in people of working age. [2,12] Approximately 12% of new cases of blindness are caused by diabetic retinopathy, and people with diabetic retinopathy are 25 to 29 times more likely than the general population to become blind within four years. [3,13] As many as 20% of patients newly diagnosed with Type 2 Diabetes (90% of cases of diabetes are Type 2), have some evidence of diabetes-related eye disease at the time of diagnosis, and approximately 5% will need immediate treatment to help prevent vision loss. Within seven years of diagnosis, 50% of patients with Type 2 Diabetes will develop diabetes-related changes to the eye. By 15 years, this number increases to as many as 85%, with 25% requiring treatment.[3] Essentially 100% of patients with Type 1 Diabetes will exhibit some diabetes-related eye disease 15 to 20 years after diagnosis.[3,8] Further, the vascular changes that occur within the eye are predictive of vascular changes occurring elsewhere in the body. [6,7]

Vision loss from diabetic retinopathy is best treated (and may be prevented) if caught in time.[4] Unfortunately, data from the U.S. and Australia show that 50% of people with diabetes are not receiving regular eye examinations. [9,10] These numbers are staggering when extrapolated to the approximately three million Canadians currently living with diabetes (one-third of whom are unaware they have diabetes); a number predicted to increase to 3.7 million by 2020.[5]

Eye Health Council of Ontario (EHCO)

It has long been clear to those involved in eye health care in Ontario that there is a need for a venue to promote inter-professional collaboration to optimize the provision of eye care and disseminate these concepts to appropriate stakeholders. Approximately six years ago, an informal Eye Care Council was created by the Ontario Association of Optometrists and Ontario Medical Association Section on Ophthalmology for this purpose. This has since evolved into the Eye Health Council of Ontario (EHCO).

The inaugural meeting of EHCO took place on December 3, 2010, following the March 31, 2010 recommendations of the Health Professions Regulatory Advisory Council (HPRAC) "Report to the Minister of Health and Long-Term Care on Inter-professional Collaboration Among Eye Care Health Professionals". This report envisioned a Council composed of optometrists and ophthalmologists working together, similar to the innovative model in Nova Scotia, building upon the foundation already established in Ontario.

The mandate of EHCO is to support the provision of accessible, quality eye care to the population of Ontario by ensuring the most effective use of the continuum of eye care professionals in the interests of patient safety, quality of care, and cost-effective delivery.

EHCO will also provide a unified voice for eye care issues at the Ministry of Health and Long-Term Care (MOHLTC), and serve as a mechanism to develop common collaborative guidelines for patient care, and as an ideal atmosphere for inter-professional collaboration outside the regulatory framework. Membership includes seven individuals from both ophthalmology and optometry representing academic, political and regulatory bodies of each profession. Both professions agreed to a governance structure wherein two co-chairs shall oversee the meetings; one chair shall be an optometrist, the other an ophthalmologist. Items require a 2/3 majority vote to be approved by EHCO. The council shall meet four times annually and host an extended meeting once per year, inviting all appropriate stakeholders (i.e. opticians, industry, CNIB, family physicians, etc). There are two observers from each College

> "Preventing blindness in people with diabetes is uniquely cost-saving and cost-effective. There are few cases in health care that are so self-evident."
>
> – JC Javitt, MD, MPH
> "Blindness: We Know What It Costs! Now What?"
> Cost of Blindness Symposium[11]

Canada's Aboriginal people have a rate of diabetes nearly five times that of non-Aboriginal people, and are at a greater risk for vision loss from diabetes and its ocular complications than any other ethnic group in Canada.[5]

Eye care providers face a challenge in the management and coordination of care for patients with diabetes. The delivery of eye care must provide cost effective and efficient use of resources to minimize preventable vision loss.

"Preventing blindness in people with diabetes is uniquely cost-saving and cost-effective. There are few cases in health care that are so self-evident."

Effectiveness of current methods of assessment for diabetic retinopathy (DR)

Assessment plays an important role in early detection and intervention to prevent the progression of diabetic retinopathy (DR). Low vision/blindness is substantially reduced among people with diabetes who receive recommended levels of care.[15] Despite the high level of efficacy, and both clinical and cost effectiveness of DR assessment and treatment, problems remain with assessment and treatment compliance. Many people with diabetes do not access regular eye examinations and the barriers that prevent them from attending for assessment are numerous.

Successful distribution of comprehensive guidelines to ophthalmologists and optometrists in many locations have not resulted in any significant impact on management practices for DR and recommendations for assessment and examination have been poorly followed.[16,17,18,19]

In Canada, only 32% of patients with Type 2 Diabetes meet the Canadian Diabetes Association [20,21] guideline-recommended schedule of evaluation for diabetic retinopathy.[22] A study that examined assessment patterns in five Canadian provinces has shown that 32% of the population with diabetes had not had an eye examination in the last 2 years and that another 32% had never had an eye examination for DR.[23]

Factors affecting non-adherence to recommended guidelines are numerous. They include lack of awareness that diabetic retinopathy can lead to blindness or that severe retinopathy can be asymptomatic.[24]

(EHCO cont'd.)

(College of Physicians and Surgeons of Ontario (CPSO) and College of Optometrists of Ontario (COO)). As per HPRAC's recommendation, a senior representative from MOHLTC participates as an observer on EHCO, providing advice to the Council and information to the Ministry and Minister on Council activities.

The ultimate goal of EHCO is the delivery of accessible, safe, quality eye care by the provider best positioned to do so in their area of the Province. In doing so, wait times will decrease, quality of care will improve, and adverse outcomes will be minimized. The independent professional Colleges (CPSO and COO) will continue to ensure public safety through regulation of their professional members. The Council, through knowledge transfer and cooperative sharing of best practice information, will be positioned to provide valuable information to all participants, including the Ministry, to continually improve the delivery of eye care in Ontario.

On September 23, 2011, the members of the Eye Health Council of Ontario unanimously passed their first inter-professional collaborative guideline, focusing on the care of patients with diabetes mellitus. We trust that these guidelines are an important first step in improving eye health care delivery for patients living with diabetes – and ultimately, for all Ontarians.

Respectfully submitted,
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Limited access to eye care professionals, particularly in remote areas [25,26,27], can play a significant role. Fear of laser treatment, guilt about poor control causing retinopathy, the inconvenience of regular attendance [24] and limited personal mobility due to poor overall health and self-reported apathy [28] may also deter patients from attending assessment appointments.

Primary care provider recommendation about the necessity of a regular eye examination is the most significant predictor of assessment for diabetic retinopathy and once such a recommendation is given, the assessment rate improves.[29] Thus, all physician/allied health staff encounters with individuals with diabetes should be used as an opportunity for education on the need for regular eye assessment and on risk factors associated with DR.

Evidence[30] indicates that increasing patient awareness of diabetic retinopathy, improving provider and practice performance, improving healthcare system infrastructure processes to make attendance more convenient for patients, using patient recall systems and better outreach to disadvantaged populations can significantly improve the rates of assessment for diabetic retinopathy.

Any chosen assessment strategy or program needs sufficient resource allocation and access to information technology to ensure comprehensive coverage and compliance with quality-assurance standards.[31]

Goal

The goal of these guidelines is to coordinate the services of ophthalmologists, optometrists, family physicians, physician specialists, nurse practitioners and allied health staff in the management of patients with diabetes, thereby ensuring the most effective use of these professionals in the interest of patient safety, quality of care, accessibility and cost effectiveness.

Roles

Primary Care Providers: Family Physician/Physician Specialist/Nurse Practitioner/ Allied Health Staff

The first step in preventing ocular complications from diabetes is identifying the population at risk. Primary care providers, including family physicians, are responsible for identifying patients with diabetes and play a key role in the care and treatment process. As the coordinators of patient care, primary care providers should promptly refer any newly diagnosed patient with Type 2 Diabetes for an assessment by an optometrist (or ophthalmologist). Patients over the age of puberty with Type 1 Diabetes need to be referred within five years of their diagnosis with diabetes.

Pediatric patients with Type 1 Diabetes should be referred for a comprehensive eye examination once the child has reached the age of 10, or has had diabetes for at least three years. Ideally, an ophthalmologist should perform this initial examination. Once the patient has reached the age of 13, in the absence of retinopathy, the patient should be followed by an optometrist (or ophthalmologist) on an annual basis.

Family physicians also need to ensure that their established patients with either Type 1 or Type 2 Diabetes, but without retinopathy, are assessed by an optometrist (or ophthalmologist) annually. Ideally, each referral would be accompanied by fasting blood glucose and HbA1c levels.

The above outlined pattern of referral to an optometrist is intended to improve patient access to timely and consistent surveillance for eye disease related to diabetes. While the Eye Health Council would recommend that initial referrals be directed to an optometrist, it is not the intent to restrict direct access to an ophthalmologist through a requirement to first see an optometrist.

Recommendations

- Refer any patients over the age of puberty with Type 1 Diabetes within five years of their diagnosis with diabetes for an assessment by an optometrist (or ophthalmologist).
- Refer any patient newly diagnosed with Type 2 Diabetes for an assessment by an optometrist (or ophthalmologist). The patient should be seen within six months of the referral.
- Refer any pediatric patient with Type 1 Diabetes for a comprehensive eye examination once the child has reached the age of 10, or has had diabetes for at least three years. Ideally, an ophthalmologist should perform

this initial examination. Once the patient has reached the age of 13, in the absence of retinopathy, the patient should be followed by an optometrist (or ophthalmologist) on an annual basis.

- At every visit, a patient with diabetes should be asked about their liaison with an optometrist or ophthalmologist to ensure appropriate monitoring.
- As mentioned later in this document, the optometrist and ophthalmologist will ensure that the next regular visit for their patient with diabetes is arranged, and will correspond with all appropriate physicians and allied health staff with ocular updates on the patient.

Optometrist

Optometrists will assess patients according to established protocols (see Specific Recommendation section that follows) for ocular complications of diabetes and should provide a report of the findings at the initial patient encounter, and thereafter when clinically indicated, to the family physician/primary care provider. It is helpful to provide an annual update if the patient is being seen more frequently. In cases where diabetic eye disease is detected, optometrists should use generally accepted criteria when managing and/or referring the patient to an ophthalmologist or retinal specialist. Referral for subsequent care should include a report to the ophthalmologist and family physician.

Ophthalmologist

Ophthalmologists are responsible for assessing and (if necessary) treating diabetic eye disease to prevent, minimize or restore vision loss. Patients with diabetic eye disease, who remain at high risk of vision loss, should continue to be monitored by the ophthalmologist. The ophthalmologist should provide a report of the findings at the initial patient encounter, and thereafter when clinically indicated, to the family physician/primary care giver and optometrist. It is helpful to provide an annual update if the patient is being seen more frequently.

All professionals share the common role of ensuring their patients are educated with respect to diabetes in general, and their specific clinical situation.

Initial / Ongoing Assessment

Initiation of assessment in people with Type 1 Diabetes

In Type 1 Diabetes, sight-threatening retinopathy is very rare in the first five years of diabetes or before puberty. [32] However, almost all patients with Type 1 Diabetes develop retinopathy over the subsequent two decades[33] and duration of diabetes is strongly associated with the development and severity of DR.[34,35,36,37]

Based on the available evidence, assessment for diabetic retinopathy in post-pubertal individuals should be initiated within five years of diagnosis.

For pre-pubertal individuals, assessment should be initiated at age 10 or within three years of diagnosis, whichever comes first.

Initiation of assessment in people with Type 2 Diabetes

Duration of diabetes is the strongest risk factor linked to the development of DR.[38,39,40,41,42.] DR risk is continuous with no evident glycemic or blood pressure threshold.[75]

At the time diabetes is diagnosed, up to 3% of patients with diabetes over age 30 have CSME or high-risk DR findings.[43,44] After a 10-year duration of diabetes, 7% of persons with diabetes were shown to have retinopathy; this number increased to 90% after 25 years. Proliferative disease was found in 20% of patients after 20 years of diabetes.[45] DR prevalence was shown to be lower in patients diagnosed with diabetes after the age of 70 years, and patients with DR had a significantly higher median duration of diabetes (5.0 years) than those without DR (3.5 years).[46]

The interval between the onset of symptoms and diagnosis in patients with Type 2 Diabetes is seven years. Given this and the foregoing information, retinopathy assessment for patients with Type 2 Diabetes should be initiated at the time of diagnosis.

Assessment intervals for people with diabetes

Since 1985, lower rates of progression to PDR and of severe visual loss from DR have been reported. This may reflect an increased awareness of retinopathy risk factors, earlier identification and care for patients with retinopathy as well as

improved glucose, blood pressure, and serum lipids management.[47]

Type 1 Diabetes

The EURODIAB Prospective Complications Study found that diabetes duration, age at onset before age 12 years, and metabolic control were significant predictors of progression, even when adjusted for presence of baseline retinopathy.[48]

Specific Recommendations

NO RETINOPATHY

Type 1 Diabetes

Available evidence indicates that an annual assessment needs to be performed by an optometrist (or ophthalmologist, or telemedicine screening if those doctors are not accessible).

Type 2 Diabetes

In the absence of any DR, assessment intervals of 19 to 24 months, as compared with intervals of 12 to 18 months, are not associated with increased risk of referable retinopathy,[49] and biennial screening has been shown to be safe and effective with no person progressing from having no retinopathy to sight-threatening retinopathy in under two years.[50] This approach reduces the number of assessments by more than 25%, considerably reducing health costs, strain on resources and relieving patients with diabetes from unnecessary examinations.[51] However, screening intervals of more than 24 months are associated with an increased risk of sight-threatening DR.[49] *The overriding concern, however, is that a move away from annual examinations will result in patients being lost to proper follow-up. This is especially true for people with poor access to care. Given that the current standard of care for people with Type 1 Diabetes is annual examinations, this will be the recommendation of these guidelines for patients with Type 2 Diabetes.* Biennial follow-up may be suggested for those patients who can be relied upon to recognize the need for recall after 24 months, or for offices that are able to recall patients effectively at the 2-year mark.

Annual assessment of patients with Type 2 Diabetes with no retinopathy needs to be performed by an optometrist (or ophthalmologist, or telemedicine screening if those doctors are not accessible).

PREGNANT WOMEN WITH DIABETES

Before attempting to become pregnant, women with Type 1 or Type 2 Diabetes should undergo an ophthalmic evaluation by an optometrist or ophthalmologist. Repeat assessments should be performed during the first trimester, as needed during pregnancy, and again within the first year postpartum. [76] This guideline does not apply to women who develop gestational diabetes, because such individuals are not at increased risk for diabetic retinopathy.

MINIMAL RETINOPATHY: Mild NPDR

- Several microaneurysms
- Visual acuity of 6/6 or better (unless other known cause of decreased vision)

Annual follow-up of patients with mild NPDR by an optometrist (or ophthalmologist, or telemedicine screening if those doctors are not accessible).

MODERATE RETINOPATHY: Moderate NPDR

- Intraretinal hemorrhages
- Hard exudates
- Nerve fibre layer infarcts/cotton wool spots (CWS)

Consider referral of a patient with moderate NPDR to an ophthalmologist (or retinal specialist) if there is any concern about DME, CSME, or other treatable disease. Assessment of patients with moderate NPDR by an eye care professional (optometrist or ophthalmologist) needs to occur at least every six months.

SEVERE RETINOPATHY: Severe NPDR

Severe NPDR includes all features of moderate NPDR, plus any one of the following:

- Intraretinal hemorrhages (≥20 in each of 4 quadrants)
- Venous beading (2 or more quadrants)
- Arteriolar narrowing

- Intraretinal microvascular abnormalities – IRMA (1 or more quadrant(s))

Very severe NPDR is defined as any 2 of the criteria for severe NPDR.

Referral to a retinal specialist (or ophthalmologist) for possible treatment. Assessment by an ophthalmologist every 2 to 4 months. Once stabilized, the patient requires follow-up by either an optometrist or ophthalmologist (or retinal specialist) so that assessment occurs at least every six months.

DIABETIC MACULAR EDEMA: DME, CSME

Clinically significant macular edema (CSME) is defined as[74]:

- Retinal thickening at or within 500 microns of the fovea
- Hard exudates at or within 500 microns of the fovea (if adjacent retina is thickened)
- Retinal thickening 1 disc diameter or larger if within 1 disc diameter of the fovea

Referral to a retinal specialist (or ophthalmologist) for treatment (laser, IVI). Follow-up by treating ophthalmologist until DME has stabilized or resolved. Once stabilized, the patient requires follow-up by either an optometrist or ophthalmologist (or retinal specialist) so that assessment occurs at least every six months.

PROLIFERATIVE DIABETIC RETINOPATHY: PDR

- Neovascularization of the disc – NVD
- Neovascularization elsewhere – NVE
- Vitreous/pre-retinal hemorrhage
- Neovascularization of the iris – NVI (anterior segment neovascularization)

Referral to a retinal specialist (or ophthalmologist) for treatment (laser, IVI, vitrectomy). Follow-up by treating ophthalmologist until regression. Once stabilized, the patient requires follow-up by either an optometrist or ophthalmologist (or retinal specialist) so that assessment occurs at least every six months.

Assessment Tools

Patient assessment by both ophthalmologist and optometrist includes a full examination of all ocular structures and a commentary on any diabetes associated ocular complications, rather than only diabetic retinopathy. Clinical examination to detect and assess DR and its severity may be performed with slit lamp biomicroscopy, ophthalmoscopy or retinal photography. It should include measurement of visual acuity, and pupils should normally be dilated for the fundus examination. Adequate sensitivity and specificity in performing the assessments are required for the examiners in all assessment processes. Minimum sensitivity required for DR has been set to 80% [53,54] or, in the case of repeated examinations that would detect DR missed at earlier examinations, to 60%. [55] Specificity levels of 90-95% and technical failure rates of 5-10% are considered appropriate. [54]

Biomicroscopy

Slit lamp biomicroscopy with a non-contact fundus lens after pupil dilation is the currently accepted standard of practice for DR detection (sensitivity of 87.4% and specificity of 94.4%), and is preferred over direct ophthalmoscopy, which has lower and more variable sensitivity even in the hands of an experienced examiner (sensitivity 56-98%, specificity 62-100%).[56] Training should ensure examiners of sufficient diagnostic accuracy and adequate sensitivity and specificity. [54,57] *Single-field retinal photography or optical coherence tomography are not replacements for a proper dilated retinal examination.*

Retinal Photography

Stereoscopic seven-field fundus photography evaluated by a trained grader is the "gold standard" method of detecting DR and has been used in most of the large clinical trials in this area. However, it is costly and time consuming and is used rarely in routine practice. Single-field retinal photography can be useful for documentation and follow-up purposes as a part of a comprehensive examination by an optometrist or ophthalmologist.

Telemedicine

Digital retinal photography is increasingly being used in screening for DR. It is not a substitute for a comprehensive eye examination,

but in circumstances where there is no optometrist or ophthalmologist available, there is level I evidence that it can serve as a screening tool for diabetic retinopathy. Patients identified as having retinopathy through this method should be referred to an optometrist or ophthalmologist for further evaluation and management.[58,59,60,61,62,63]

Fundus imaging has the additional advantage of being perceived by patients as a valuable educational resource.[24] It can be performed with dilated pupils or with non-mydriatic cameras through non-dilated pupils.[64] The chosen technology, along with the number of camera fields taken, will influence sensitivity of screening. [65]

Fluorescein Angiography (FA)

Fluorescein angiography has no role in screening for DR, but is essential in late-stage disease to detect and delineate retinal ischemia. It is an invasive examination with an inherent albeit small risk of significant side effects, some mild and transient, some severe (such as anaphylaxis or cardiac arrest).

Optical Coherence Tomography (OCT)

Optical coherence tomography is a non-contact, non-invasive technique that produces cross-sectional images of the retina and optic disc similar to histological sections. It has an axial resolution of 5 µm with newer instruments and provides qualitative and quantitative data that correlate well with fundus stereophotography or biomicroscopy to diagnose diabetic macular edema. It has good reproducibility and provides accurate measurements of retinal thickness.[67,68]

OCT appears useful to detect macular thickening in the early stages of diabetic retinopathy in patients with retinopathy and no clinical evidence of macular edema, enabling closer follow-up for early DME.[69,70] However, OCT does not help in predicting which eyes with subclinical DME will progress to clinically significant DME.[71]

OCT is an effective qualitative and quantitative method for detecting early macular thickening and following progression or regression of macular edema over the course of treatment, and has been incorporated as a routine measure in numerous ongoing studies of new treatments for DR.

Current data suggest that there is little reason to routinely obtain OCT in eyes with diabetes and no retinopathy or mild to moderate diabetic retinopathy when clinical examination fails to show macular edema.[72] However, OCT should be strongly considered when any change in macular architecture, or any unexplained change in best-corrected acuity, is encountered.

Conclusion

The coordination of health care resources is essential in the care and treatment of patients at risk for ocular complications from diabetes. Timely optometric assessment of newly diagnosed diabetic patients will identify patients at risk for diabetic eye disease. Early intervention and treatment of eye disease through appropriate and timely referral for ophthalmologic care will assist in the preservation of quality vision for patients with diabetes. Inter-professional guidelines and generally accepted management and referral criteria will ensure appropriate coordination of care and the most effective use of health professional resources.

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Appendix: Diabetic Retinopathy (DR) Disease Severity Scale

No Apparent Diabetic Retinopathy

Non-proliferative Diabetic Retinopathy (NPDR)

- Mild to moderate NPDR – micro-aneurysms, intra-retinal hemorrhages, hard exudates, foveal avascular zone abnormalities
- Moderate to severe NPDR – cotton wool spots, venous beading, intra-retinal microvascular abnormalities (IRMA)
- Severe NPDR (4-2-1 rule) – any one of: severe (>20) intra-retinal hemorrhages in each of four quadrants; definite venous beading in two or more quadrants; prominent IRMA in one or more quadrant(s)
- Very severe NPDR – any two of the above criteria

Proliferative Diabetic Retinopathy (PDR) – one or more of:

- Neovascularization of the disc – NVD (particularly greater than 1 disc diameter in size)
- Neovascularization elsewhere – NVE
- Vitreous/pre-retinal hemorrhage
- Neovascularization of the iris – NVI (anterior segment neovascularization)

Clinically Significant (Diabetic) Macular Edema (CSME)

- Any retinal thickening within 500 microns of the center of the macula (fovea), or;
- Retinal thickening at least one disc area in size, any part of which is within one disc diameter of the center of the macula (fovea), or;
- Hard exudates within 500 microns of the center of the macula (fovea) with adjacent retinal thickening.

It is important to note that hard exudates are a sign of current or previous macular edema. CSME may be focal (leakage from micro-aneurysms or IRMA) or diffuse (leakage from the underlying capillary bed). CSME is the most common cause of decreased vision and blindness among patients with diabetes, and may occur concurrent with any stage of diabetic retinopathy.

7.5 Patients with Hypertension

Description

Hypertension is a common and insidious systemic condition that may contribute to the development of potentially vision-threatening complications. These include, but are not limited to, arteriosclerosis, vascular occlusions and obstructions, retinal hemorrhages, edema, ischemia and neovascularization, optic neuropathies, and oculomotor anomalies arising from neuropathies affecting the third, fourth, or sixth cranial nerves. These findings may indicate a need for systemic medical assessment and intervention in the interest of maintaining the patient's general health. The need for such intervention may be urgent in some circumstances.

Clinical Guideline

The patient's medical history should be explored to determine the duration of the condition, any associated visual symptoms and the presence of any complications or other cardiovascular disease. The patient's management regime should be reviewed, noting:

- any medications taken, with dosages and schedule where applicable;
- frequency and usual results of blood pressure monitoring; and
- any history of other medical interventions, diagnostic procedures or ongoing monitoring related to cardiovascular disease.

The name of the patient's primary healthcare practitioner should be noted in the record to facilitate communication and coordination of the patient's care.

In addition to the normal complement of required clinical information to be obtained on each patient, certain supplementary procedures may be useful in some cases, depending on clinical findings. Such procedures may include:

- blood pressure measurement;
- visual field assessment;
- contrast sensitivity testing;
- fundus photography (or other ocular imaging procedures);
- optical coherence tomography (OCT).

Coordination of Care

It is always beneficial, when signs of hypertensive eye disease exist, to send written letters or reports to relevant members of the patient's health care team and to keep copies of such documentation in the patient's record.

Additional references relevant to this topic are:

American Optometric Association Clinical Practice Guidelines (**www.aoa.org**):

•CPG 1 Comprehensive Adult Eye and Vision Examination

First Published: April 2007

Revised: February 2013

June 2014

7.6 Cycloplegic Refraction

Description

Objective and subjective refraction done under cycloplegia can provide useful information in situations where sustained accommodative effort is suspected to be contributing to symptoms or obscuring a full diagnosis of the clinical problem.

Clinical Guidelines

Optometrists will consider performing a cycloplegic refraction for:

- infants, toddlers, preschoolers;
- noncommunicative patients;
- children with behavioural and/or academic performance issues;
- children and young adults with hyperopia, on their first visit, particularly if associated with an eso deviation;
- children and young adults presenting with a strabismus on their first visit, particularly if the direction of the deviation is esotropia;
- patients with variable and inconsistent subjective responses during manifest refraction;
- patients whose symptoms are suspected to be arising from accommodative spasm (i.e., latent hyperopia, pseudomyopia);
- patients whose binocular function is subnormal;
- patients who appear to have a subnormal amplitude of accommodation for their age, or who have other signs or symptoms suggestive of accommodative dysfunction;
- patients who are planning to undergo a surgical procedure that is intended to permanently alter their refractive error; and
- patients whose symptoms seem unrelated to the nature or degree of the manifest refractive error.

The specific cycloplegic agent to use in each case should be selected with the goal of providing adequately deep suppression of accommodation while at the same time minimizing the length of time that the patient will be inconvenienced by blur or excessive photophobia.

The agent selected and specific dosage will be influenced primarily by the age of the patient and secondarily by the degree of iris pigmentation. Patients with darker irides often require a more potent cycloplegic agent or a higher dosage than patients with lighter irides (e.g., two drops separated by a five minute time interval rather than a single drop in each eye).

Cyclopentolate hydrochloride (0.5% and 1% drops) is the most widely used cycloplegic agent available at this time. It provides the best compromise between efficacy and duration of action1, with one to two drops of 1% solution producing adequate cycloplegia within 25-30 minutes of instillation and lasting 3-24 hours in the majority of cases[2].

Atropine (0.5% and 1% concentrations in ointment and drop form, respectively) is advocated by some authorities for the purpose of producing maximal cycloplegia in very young children, but it usually requires administration of the drug up to 3 days before the refraction and its effects are excessively long-lasting[1].

Tropicamide (0.5% and 1% drops) may also be effective for use in adult patients, offering a rapid onset of action (20-30 minutes) and a short duration (30 minutes to 4 hours)[1]; however it may not provide a reliable degree and consistency of cycloplegia, especially in patients with dark irides and significant hyperopia[1].

Optometrists need to exercise considerable clinical judgment in interpreting the refractive findings obtained under cycloplegia and prescribing an appropriate refractive correction. The final prescription decision will depend on:

- a comparison of the cycloplegic versus non-cycloplegic refractive findings;
- the patient's age;
- the patient's symptoms;
- the degree of hyperopia and/or esophoria; and
- the presence or absence of strabismus.

Properties of common cycloplegic agents that may be used are summarized in the *The Use and Prescribing of Drugs in Optometric Practice* **(OPR 4.4)**.

First Published: April 2007

Revised: April 2014

February 2015

[1] American Optometric Association Clinical Practice Guidelines: CPG 16 Care of the Patient with Hyperopia
[2] Bartlett et al. Ophthalmic Drug Facts. St. Louis: Lippincott, 1989:22-27

7.7 Dilation and Irrigation of the Naso-Lacrimal Ducts

Description

Dilation and irrigation of the naso-lacrimal ducts may be used as diagnostic or treatment procedures. These procedures temporarily enlarge the punctal opening to the canaliculi for insertion of occlusion devices and/or the irrigation of material from the canaliculi and the naso-lacrimal ducts and/or to maintain complete patency of the system.

Clinical Guideline

Signs and symptoms consistent with epiphora are determined by the patient history and slit lamp examination. Tests such as the fluorescein dye disappearance test for lacrimal outflow deficiency can be helpful in confirming the diagnosis of epiphora.

In dry eye conditions, knowing the patency of the drainage system is essential if epiphora is present.

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January 2018

7.8 Shared Care in Refractive Surgery

Description

The term 'Refractive Surgery' (RS) is a general term for the various forms of surgery used to correct refractive errors of the eye. This includes techniques that use lasers and other forms of electromagnetic energy, implantable lenses and devices, and incisional techniques. Optometrists provide preoperative and postoperative care to RS patients both in their offices and within surgical centres.

Refractive surgery is one of the situations in which optometrists often participate in a shared care relationship **(OPR 4.8)** with another healthcare practitioner. Shared care arrangements are intended to assist in the delivery of effective, efficient, high quality patient care. This standard and guideline addresses the sharing of responsibilities, the communication of patient information, and the financial arrangements within shared care situations.

Clinical Guideline

All optometrists should possess a reasonable degree of knowledge about RS in order to discuss treatment options with patients in general terms.

The following guidelines apply to members providing pre- and postoperative RS care.

Counselling

The purpose of counselling is to enable patients to make informed decisions about treatment options. Counselling is based upon an appropriate case history and clinical examination. In the case of RS, optometrists share this responsibility with surgeons.

Preoperative Care Considerations

- general information, including a description of the procedure, expected outcomes, normal healing course, and expected postoperative care schedule and procedures.
- potential benefits including reduction or elimination of refractive error and need for corrective lenses.
- potential risks and complications including surgical complications, healing complications, optical problems associated with over or under correction, and potential adaptation problems associated with post-surgical status.
- provider options such as available surgical facilities and qualified surgeons, as well as those qualified to provide preoperative and/or postoperative care.
- practitioner responsibilities so patients are informed of who will provide each aspect of their care.

Postoperative Care Considerations

The postoperative care regimen depends upon the surgical procedure and any complications involved:

- in a shared care environment, the results of postoperative assessments are

communicated to surgeons.

- any urgent or unexpected complications that arise should be communicated to surgeons in a timely manner.
- any changes to the prescribed postoperative drug regimen should be communicated to surgeons in a timely manner.
- optometrists should ensure that patients understand how to access emergency care.

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7.9 Patients with Learning Disability

Description

Learning disability is a condition where a significant discrepancy exists between the potential for learning and the actual academic or vocational achievement. Patients with suspected or recognized learning disability often consult optometrists to determine whether a vision problem could be a contributing factor.

By assessing and managing vision problems associated with learning disability, optometrists act as members of a multidisciplinary team that may also include one or more of the following professionals:

- another optometrist who is proficient in visual information processing (visual perception) evaluation;
- educator;
- psychologist;
- physician;
- occupational therapist;
- audiologist; and/or
- speech-language pathologist.

Clinical Guideline

Evaluation of patients with suspected or recognized learning disability should emphasize a thorough review of case history, visual efficiency skills and possibly visual information processing skills, in addition to the fundamental components of an oculo-visual assessment.

Case History:

A comprehensive case history should include discussion regarding:

- the chief concern or reason for the visit;
- the specific nature of the current learning (and vision) problems;
- the patient's medical history, including pertinent risk factors for vision problems and learning disability (perinatal events, childhood illnesses, premature birth, etc.);
- the patient's developmental history, including achievement of milestones for motor, language and social skills;
- family history of eye/vision problems, health conditions, learning difficulties; and
- the patient's academic/educational/vocational history, including:
  - Previous assessments and interventions by eye care or other professionals
  - Current achievement levels and placement
  - Current interventions by eye care or other professionals.

Visual Efficiency Skills:

Refraction and visual acuity should be assessed using tests appropriate to the patient's age and ability to give accurate subjective responses. Cycloplegic refraction should be utilized, as needed, to obtain conclusive results.

A comprehensive assessment of binocular vision skills should include evaluation of:

- Saccadic and smooth pursuit eye movements;
- Phoria or Strabismus, at distance and near;
- near point of convergence;
- fusional vergence amplitudes, at distance and near;
- vergence facility;
- amplitude of accommodation;
- accuracy of accommodation (lag);
- relative accommodation;
- accommodative facility;
- fixation disparity; and
- Stereopsis.

Visual Information Processing (Visual Perception):

Additional evaluation of visual processing also may be undertaken, to assess visual perception and its integration with motor, auditory, language and attention skills.

A visual perception assessment should utilize current, age-appropriate, normative-referenced tests in the evaluation of:

- visual Spatial Orientation Skills (Bilateral integration, laterality, and directionality);
- visual Analysis Skills (visual discrimination, visual figure ground perception, visual closure, visual memory, visualization);
- visual-Motor Integration;
- eye-Hand Coordination;
- auditory-Visual Integration;
- visual-Verbal Integration; and
- reading and Spelling.

Treatment:

Although vision problems may be associated with learning difficulties, they are rarely the sole factor. Therefore, specific and problem-oriented treatment goals should be established.

The optometrist should provide counselling with respect to:

- treatment goals and options;
- prognosis;
- expected duration of treatment; and
- associated fees.

Provision of such counselling should be recorded in the patient record. The patient record also should include the details of treatment and follow-up, any changes to the treatment plan, the fees charged, and copies of any written reports or correspondence. Informed consent is obtained prior to treatment.

Optometric treatment of vision problems associated with learning disability is delivered in cooperation with other professionals, and does not replace conventional educational / vocational programming. Interdisciplinary communication, consultation and referral often are necessary, to fully manage the learning disability.

Additional Information

Additional references relevant to this topic include:

- American Optometric Association CPG-20 - Care of the Patient with Learning Disabilities www.aoa.org
- Mitchell Scheiman, OD and Michael W. Rouse, OD, MS, FAAO. Optometric Management of Learning Related Vision Problems, 2nd Edition. Elsevier, Inc. 2006.

First Published: April 2012

Revised: April 2014

Effective Date: April 2014

7.10 Orthokeratology

Description

Orthokeratology (Ortho-K) involves the wearing of specially designed rigid gas permeable (RGP) contact lenses, often overnight, to progressively and temporarily alter the curvature of the cornea. This procedure may be offered by optometrists as an option for vision correction (most commonly myopia and/or astigmatism), and is being investigated for myopia control in children.

Clinical Guideline

Optometrists not performing Ortho-K should maintain current, general knowledge of Ortho-K therapy so that they can identify and refer patients who may benefit from this treatment.

When optometrists share the management of patients undergoing Ortho-K therapy, there should be clear and documented communication outlining the expectations regarding the frequency of visits to each optometrist. It is important that patients understand which optometrist is their primary point of contact, and overlap of testing should be minimized whenever possible.

References:

Additional references relevant to this topic include:

1 **http://www.myopiaprevention.org/references_orthokeratology.html**

2 Cho P, et. al. Good clinical practice in orthokeratology. Contact Lens & Anterior Eye 31 (2008) 17–28.

First Published: January 2014

Revised: April 2014

7.11 Patients With Dry Eye Disease

Description

The tear layer overlying the cornea must create a uniform optical surface, lubricate and nourish tissue, remove metabolic and cellular debris, and provide antimicrobial protection.

Dry eye disease (DED) is much more complex than the name suggests, defined by the International Dry Eye Workshop in 2007 as:

> *'a multifactorial disease of the tears and ocular surface that results in symptoms of discomfort, visual disturbance, and tear film instability with potential damage to the ocular surface . . . accompanied by increased osmolarity of the tear film and inflammation of the ocular surface'.*

Symptoms may be episodic or chronic. Although DED is broadly categorized as aqueous deficient dry eye (ADDE, secondary to lacrimal gland insufficiency) or evaporative dry eye (EDE, secondary to meibomian gland dysfunction, MGD), these categories are not mutually exclusive; patients typically present with mixed-mechanism disease. The common mechanisms and endpoints of DED, regardless of etiology, are hyperosmolarity, inflammation, and tear film instability.

Optometrists possess the knowledge, skill, and judgment to diagnose and treat DED.

Clinical Guideline

The use of validated questionnaires may be of assistance to augment but not replace a detailed case history.

Patients may benefit from more advanced diagnostic assessment, including but not limited to:

- quantification of tear osmolarity;
- assessment of tear film thickness and integrity through, among other means, interferometry or anterior segment optical coherence tomography (OCT).

Patients may also benefit from more advanced medical and/or surgical intervention, including but not limited to:

- thermal pulsation treatment for MGD;
- meibomian gland probing;
- lid margin debridement;
- referral for surgical punctal occlusion or tarsorraphy;
- artificial tears formulated from autologous serum (specifically for patients with concurrent autoimmune disease).

Members should consult the **National Dry Eye Disease Guidelines for Canadian Optometrists**, as developed by The Canadian Dry Eye Disease Consensus Panel for the Canadian Journal of Optometry **(Appendix 1)**.

Additional Documents Relevant to this Topic are:

1. International Dry Eye Workshop (DEWS). The definition and classification of dry eye disease: report of the Definition and Classification Subcommittee of the International Dry Eye Workshop. Ocul Surface 2007;5:75-92.
2. Bujak MC. Dry eye: a comprehensive approach to diagnosis and management. Ophthalmology Scientific Update 2012.
3. Jackson WB. Management of dysfunctional tear syndrome: a Canadian consensus. Can J Ophthalmol 2009;44:385-94.
4. American Academy of Ophthalmology Corneal/External Disease Panel. Preferred Practice Pattern Guidelines. Dry Eye Syndrome – Limited Revision. San Francisco, CA: American Academy of Ophthalmology; 2011.
5. MacIver S, et al. The new normal in managing dry eye disease. Optometry Rounds 2013;1(2).
6. Care of the Patient with Ocular Surface Disorders (CPG10) **(www.aoa.org)**
7. Care of the Patient with Conjunctivitis (CPG11) **(www.aoa.org)**

First Published: April 2014
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CJO RCO

CANADIAN JOURNAL *of* OPTOMETRY | REVUE CANADIENNE D'OPTOMÉTRIE

SPECIAL SUPPLEMENT

NATIONAL DRY EYE DISEASE GUIDELINES FOR CANADIAN OPTOMETRISTS

Screening, Diagnosis and Management of Dry Eye Disease:
Practical Guidelines for Canadian Optometrists

CANADIAN ASSOCIATION OF OPTOMETRISTS
ASSOCIATION CANADIENNE DES OPTOMÉTRISTES

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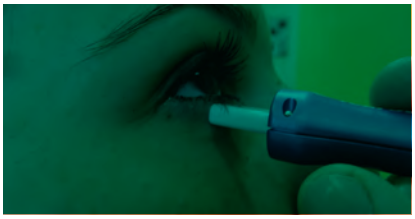

On the Cover
Meibomian Gland Evaluator (TearScience) used to express the meibomian glands with a consistent force.

Screening, Diagnosis and Management of Dry Eye Disease: Practical Guidelines for Canadian Optometrists

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The Canadian Dry Eye Disease Consensus Panel was developed to create a national guide for the clinical management of dry eye disease in an effort to assist Canadian optometrists in the diagnosis and management of one of the most prevalent ocular diseases they will encounter. The panel consists of experts from multiple areas of optometry including private practice, academia and research. Experts were chosen based on their clinical acumen in the field of dry eye disease management, publication frequency, clinical research and recommendations from Canadian colleagues citing their expertise in this area of practice. Due to Canada's vast geographical area, experts were chosen from different regions of the country. The West Coast, Prairies, Ontario, Quebec, and the Maritimes were all represented. Editorial support was provided by Paul Karpecki, O.D. and Derek Cunningham O.D., both of whom are Canadians who are involved in dry eye/surgical practices in the United States. Unrestricted educational funding was provided by Allergan Inc, Canada.

ABBREVIATIONS:

ALA = alpha-linolenic acid; CL = contact lens; CN7 = seventh cranial nerve/facial nerve; CTT = cotton thread test; DED = dry eye disease; DEQ = Dry Eye Questionnaire; DEQ-5 = 5-item Dry Eye Questionnaire; DHA = docosahexaenoic acid; EFA = essential fatty acid; EPA = eicosapentaenoic acid; FL-TBUT = fluorescein TBUT; GLA = gamma-linolenic acid; GPC = giant papillary conjunctivitis; IDEEL = impact of dry eye on everyday life; IOP = intraocular pressure; KCS = keratoconjunctivitis sicca; LWE = lid wiper epitheliopathy; LG = lissamine green; MG = meibomian gland; MGD = MG dysfunction; MMP = matrix metalloproteinase; NIBUT = non-invasive break-up time; NSAIDs = non-steroidal anti-inflammatory drugs; OCT = optical coherence tomography; OSDI = Ocular Surface Disease Index; PRTT = phenol red thread test; SLE = slit lamp exam; SLK = superior limbic keratoconjunctivitis; SPEED = standard patient evaluation of eye dryness questionnaire; SPK = superficial punctate keratitis; SS = Sjögren syndrome; TBUT = tear break-up time; TMH = tear meniscus height; ULMS = upper lid margin staining

INTRODUCTION

Dry eye Disease (DED) is one of the most common conditions encountered in optometric practice. The reported prevalence of this disease ranges from 7.8 to 29%.[1-5] These estimates vary depending on the definition of DED used, and the age of the cohort and country where the study was conducted. Regardless of the actual number, the appropriate diagnosis and management of this common disease is critical to meeting the eye care needs of a large segment of the general North American population. However, poor accessibility of eye care services, costs, as well as the restriction of existing treatment modalities to primary care practitioners are some of the reasons contributing to the lack of care in this population. Further, some consider DED to be a symptom rather than a disease and, consequently, fail to realize the importance of diagnosis and treatment to prevent progression to chronic ocular surface disease.

Recent scientific and clinical advances have increased our understanding of this complex group of diseases.[10] The 2007 Dry Eye Workshop (DEWS) report created a comprehensive definition for DED that is the most widely accepted version to date. The authors of the report defined DED as a "multifactorial disease of the tears and ocular surface that results in symptoms of discomfort, visual disturbance and tear film instability with potential damage to the ocular surface. It is accompanied by increased osmolarity of the tear film and inflammation of the ocular surface".[10] The complexity of DED is suggested by this multidimensional definition, as well as by the density of the document that summarized the body of knowledge. Other groups including the Delphi panel[11] in 2006, and a group of Canadian ophthalmologists in 2008[12] have created consensus guidelines. A comprehensive review of meibomian gland disease (MGD), a primary cause of evaporative DED, was subsequently published by the Tear Film and Ocular Surface Society in 2011.[13]

DED may be broadly classified as aqueous deficient or evaporative, although at a clinical level these categories often overlap and coexist.[10] The most severe and well-defined form of aqueous deficient DED is Sjögren syndrome (SS), a chronic autoimmune disease that preferentially attacks the lacrimal and salivary glands, as well as many other organ systems (see www.sjogrenscanada.org). The American European Consensus group for the diagnosis of SS includes a measure of aqueous production, non-anesthetized Schirmer, as a criterion for diagnosis.[14] The phenol red thread test (PRTT) can also be used to diagnose aqueous deficiency.[15] The evaporative form of the disease is often observed clinically by the breakup of the tear film, which is most typically measured invasively with the use of fluorescein.[16] Clinicians and patients would benefit from simple classification and disease staging systems.

Symptoms play an important role in the diagnosis of DED and evaluating treatment outcomes. One of the difficulties is that a patient's experience of the disease may be far more uncomfortable than it appears to a clinician when examining the clinical signs.[6] Four validated questionnaires [Ocular Surface Disease index (OSDI),[17] 5-item Dry Eye Questionnaire (DEQ-5),[18] McMonnies[19] and Standard Patient Evaluation of Eye Dryness (SPEED) questionnaire[20]] have been shown to be useful tools to identify patients with mild symptoms that would otherwise be overlooked when simple questions about dryness are used alone; for example, in those patients who present with symptoms of intermittent blurry vision only.

There is no single objective test that leads to the diagnosis of DED. Clinicians tend to use slit lamp findings such as tear meniscus height, lid observations and corneal staining consistently in their assessments. Many other useful tests are available such as tear film osmolarity and inflammatory markers as well as conjunctival staining, but these are as yet not widely used because of the chair time and expense, and because simple and effective treatment options had not, until recently, been identified. Further, there is inconsistency among signs and symptoms, and the results of various tests for DED may not correlate with each other.[6,7] This variability among signs and symptoms can lead to confusion about the best course of treatment. For those patients who receive a diagnosis of DED and who initiate treatment, there is little guidance in the published literature to gauge treatment success.

It is with this knowledge that a group of eye care professionals gathered to create a practical clinical approach to DED. The objective of this document is to address some of the challenges associated with practical and effective screening, diagnosis and management strategies for DED in contemporary clinical practice. Further, a simplified clinical approach to categorizing the individual patient's disease into simple bins, identifying whether the disease is "episodic", "chronic" or "recalcitrant" is intended to facilitate a straightforward treatment paradigm that can be applied during most patient encounters.

SCREENING FOR DRY EYE DISEASE

Given the high prevalence and variability of symptoms, almost every adult presenting for a primary care examination should be considered to be a DED suspect until proven otherwise. The diagnosis of DED begins with a quick, selective screening. The clinician asks a few targeted questions, identifies risk factors, and conducts a brief screening examination. Patients identified with this process should be considered for a more comprehensive DED workup.

CASE HISTORY

In addition to a conventional case history, the answers to four simple questions serve as an easy and quick indicator of the likelihood of DED **(Figure 1)**.

1. Do your eyes feel uncomfortable?
2. Do you have watery eyes?
3. Does your vision fluctuate, especially in a dry environment?
4. Do you use eye drops?

If yes to any of the above questions:
1. Do you have dry mouth?

An affirmative response to any of these questions should raise the suspicion of DED and prompt a screening examination. In particular, the presence of dry eye along with dry mouth should prompt consideration for referral to another health care professional, such as a rheumatologist, for SS. Remember that ocular symptoms can occur as a result of many conditions, so be sure to rule out the myriad of other conditions that may mimic DED (**Table 1**).

RISK FACTORS

If the answers to the four screening questions suggest the possibility of DED, the presence of risk factors should be evaluated, even if the symptoms are mild. The most important risk factors associated with DED include: a history of lid, ocular, or refractive surgery; age over 40 years; female gender; use of medications known to cause DED **(Table 2)**; presence of certain systemic diseases **(Table 3)**; smoking; computer vision syndrome; and frequent exposure to harsh environments (dust, dry air, cooling and heating units, airplanes).

Table 1. *Conditions that may mimic dry eye disease.*

Allergic ocular diseases
Anterior basement membrane dystrophy
Binocular vision problems
Computer vision syndrome
Conjunctivochalasis
Contact lens/solutions induced problems
Giant papillary conjunctivitis
Infectious blepharitis
Lid issues (entropion, ectropion, lagophthalmos, floppy eyelid syndrome)
Ocular pemphigoid
Pingueculitis
Salzmann nodular degeneration
Superior limbic keratoconjunctivitis
Visual system misalignment

Table 2. *Medications with the potential to induce or exacerbate dry eye disease*[10]

Drug class	Examples	Trade Name
Antiarrhythmic drugs	Disopyramide	Norpace® and Rythmodan®
	Quinidine	BiQuin®
Antihistamines	Diphenhydramine	Benadryl®
	Hydroxyzine	Vistaril®, Atarax®
	Fexofenadine	Allegra®
	Loratadine	Claritin®
Anti-Parkinson	Benztropine	Cogentin®
	Trihexyphenidyl	Artane®
Antipsychotics	Chlorpromazine	Thorazine®, Largactil®
	Haloperidol	Haldol®
Antispasmodics	Hyoscine butylbromide	Buscopan®
	Oxybutinin	Ditropan®, Lyrinel® XL, Lenditro®
	Tolteridine	Detrol®, Detrusitol®
Tricyclic antidepressants	Amitriptyline	Elavil®
	Nortriptyline	Aventyl®, Pamelor®, Norpress®, Allegron®, Noritren®, Nortrilen®
Diuretics	Hydrochlorothiazide	Hydrodiuril®
Beta-blockers	Atenolol	Tenormin®
	Metoprolol	Lopressor®
Retinoids	Isotretinoin	Accutane®
Hormone replacement therapy	Estrogen supplements	
Selective serotonin reuptake inhibitors	Fluoxetine	Prozac®
	Fluvoxamine	Luvox®
	Paroxetine	Paxil®
	Sertraline	Zoloft®
Systemic chemotherapy	Cyclophosphamide	Cytoxan®, Procytox®
	5-fluorouracil	5-fluorouracil, 5-FU

Table 3. *Systemic diseases associated with dry eye disease*[10]

Androgen deficiency
Chronic hepatitis C
Diabetes insipidus
Diabetes mellitus
Hematopoietic stem cell transplantation
Pemphigoid
Primary biliary cirrhosis
Psoriasis
Rheumatoid arthritis
Rosacea
Scleroderma
Sjögren syndrome
Stevens-Johnson Syndrome
Systemic lupus erythematosus
Thyroid disease
Vitamin A deficiency

SCREENING EXAMINATION

The preliminary screening examination becomes necessary when a patient responds positively to any of the first four screening questions (see **Figure 1**), especially in the presence of known risk factors for DED. The screening examination is simple and is intended to be part of a regular ocular health assessment. It is based on a 3-step approach:

1. Evaluate facial symmetry, eyelids, lashes, blink, and lid closure

The practitioner should begin by looking for irregularities, crusting, redness, and other evidence of lid disease. Observe blink rate and completeness of blink, especially in patients who use computers or hand-held devices extensively.

When evaluating the lids consider the role of rosacea as many patients with this condition

have ocular manifestations.[21-24] The nose, cheeks, forehead, and chin are the most commonly affected areas. Ocular rosacea is associated with blepharitis, conjunctivitis, inflammation of the lids and meibomian glands (MG), interpalpebral conjunctival hyperemia and conjunctival telangiectasia. It is important to note that ocular signs may precede dermatological manifestations of rosacea by years; however, in the majority of cases, they develop concurrently.[21]

Four types of rosacea are recognized by the National Rosacea Society, of which two are common. Papulopustular rosacea primarily affects women in middle age (aged 30-40 years) who complain of episodic eye dryness and discomfort induced by contact lenses (CLD). These patients often have a history of flushing when exposed to triggers. External examination reveals small erythematous papules covered with pinpoint pustules. Phymatous rosacea primarily affects older men (aged >55 years) who present with thick lids, pustules, and rhinophyma.

2. Evaluate tear film: TBUT-using fluorescein strips

Instill fluid from a fluorescein strip wetted with saline onto the lower lid tarsal conjunctiva and have the patient blink normally. Do not use a fluorescein/anesthetic combination because anesthetic drops initiate reflex tearing and promote conjunctival hyperemia. Thus, evaluation of TBUT with a combination product is less valid. Observe the ocular surface with a biomicroscope and cobalt blue filter. Have the patient blink once and hold their eyes open either for as long as possible, or until until a black area is observed, indicating the break-up of the tears. Generally, a finding of < 10 seconds raises suspicion for DED.

Figure 1. *Screening for dry eye disease.*

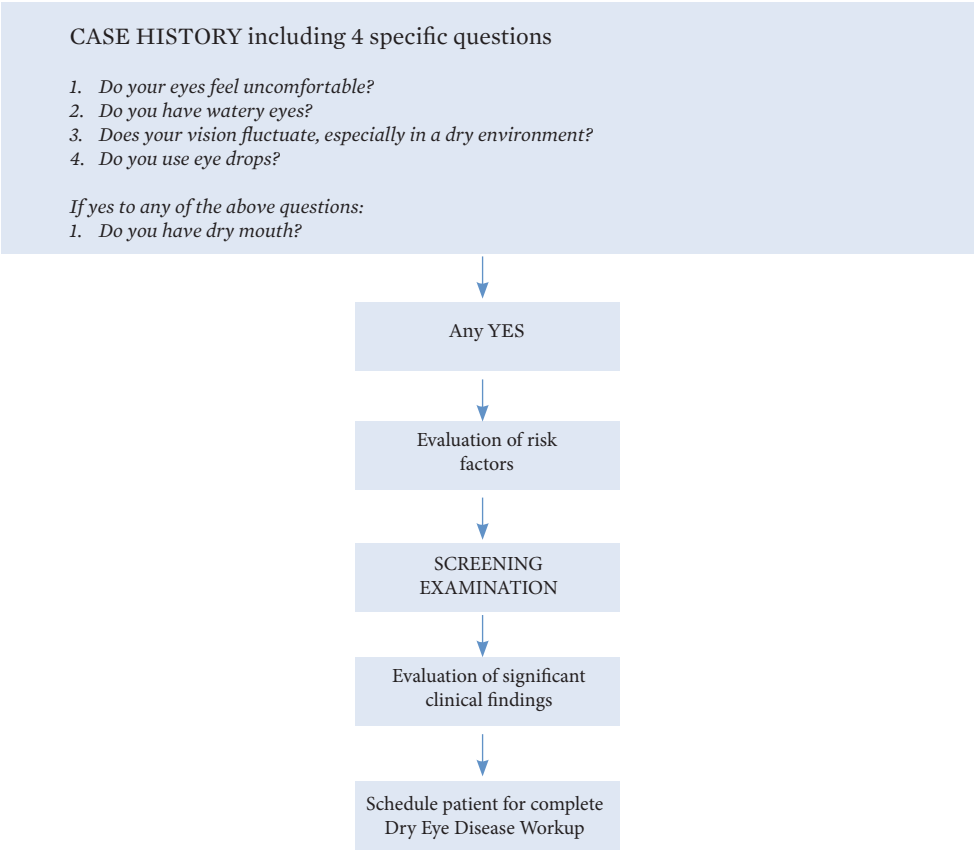


Table 4. *Criteria for Sjögren Syndrome (SS)*

Group	Criteria
American-European Consensus Group, 2002[14]	Primary SS: requires 4 of the 6 criteria, as long as either item 4 (histopathology) or 6 (serology) is positive. Secondary SS: presence of connective-tissue disease, symptoms of oral or ocular dryness, in addition of 2 of the criteria #3, #4 or #5. 1. Ocular symptoms > 3 months 2. Oral symptoms (dry mouth, swollen salivary glands or frequent use of liquids to swallow dry food) 3. Ocular signs Schirmer's test without anesthesia (<5 mm/5 min) Positive vital dye staining 4. Oral signs (histopathology): Abnormal salivary scintigraphy findings Abnormal parotid sialography findings Abnormal sialometry findings 5. Positive minor salivary gland biopsy findings 6. Positive anti-SSA or anti-SSB antibody test results
Sjögren's International Collaborative Clinical Alliance (SICCA) adopted by the American College of Rheumatology, 2009[26]	At least 2 of the 3 following findings need to be met: 1. Positive serum anti-SSA and/or anti-SSB antibodies or positive rheumatoid factor and antinuclear antibody (ANA) titer of at least 1:320 2. Ocular staining score of at least 3. 3. Presence of focal lymphocytic sialadenitis with a focus score of at least 1 focus/4 mm^2 in labial gland biopsy samples

3. Fluorescein corneal staining

After evaluating the TBUT, use the cobalt filter to observe corneal staining. Evaluate the location, pattern and severity of staining. Corneal staining associated with DED is typically evident in the lower part of the cornea, and tends to be confluent.

In summary, the presence of symptoms as revealed by the screening questions, combined with one or more signs on the screening evaluation, should prompt the clinician to proceed to a more comprehensive DED workup, either on the same or different day.

DIAGNOSIS: THE COMPLETE DRY EYE DISEASE WORKUP

Optometrists normally attempt to address all of a patient's concerns in a single primary care examination. However, the evaluation of patients with DED requires specific testing and more than an additional 5 or 10 minutes tacked on to a routine examination. Once a patient has been identified as being a DED suspect through screening, a full DED workup is recommended. This model is similar to that used by most optometrists to evaluate patients at risk for glaucoma. These patients typically return for a glaucoma workup, at which time further tests (i.e., tonometry, optic nerve head evaluation, visual field testing, pachymetry, imaging and gonioscopy) are performed. Similarly a targeted workup is required to adequately address DED.[25]

The tests described in this section comprise the comprehensive DED workup and assist the practitioner in evaluating contributing factors, such as aqueous deficiency, evaporative causes, CL wear, solution toxicity, and others. The workup should include a detailed case history including a full list of medications, with close attention to those that may contribute to ocular dryness **(Table 2)**. Careful attention to the order of testing is important to ensure that the outcome of the overall workup is not affected. As the clinician navigates through the tests, a differential diagnosis should emerge leading to an evaporative or aqueous deficient etiology, while keeping in mind that both types may coexist. The frequency of symptoms (episodic versus chronic) guides the management of the patient.

The presence of prolonged symptoms, dry mouth, low tear flow, and ocular staining prompts the clinician to consider the presence of SS. Further questioning around related symptoms is

helpful, including but not limited to, the presence of neuropathy, gastrointestinal symptoms, Raynaud syndrome and others (for more information please visit www.sjogrenscanada.org). There are two prevailing diagnostic schemes for SS, namely, the American-European Consensus Group[14] and the Sjögren's International Collaborative Clinical Alliance (SICCA) adopted by the American College of Rheumatology (2002) **(Table 4)**.[26] If SS is suspected, referral to a rheumatologist should be initiated highlighting the findings and contributory history. A solid co-management arrangement generally facilitates the most appropriate ongoing care for the patient.

Keep three key questions in mind when evaluating a patient with DED:

1. What is the frequency (episodic or chronic) and severity of symptoms and how do they affect the patient's activities (reading, driving, watching TV, etc.)?
2. What portion of the ocular dysfunction is likely attributable to evaporative causes (evaluate MG) or aqueous deficiency (evaluate quantity/volume)?
3. Is the integrity of the ocular surface compromised?

With these questions in mind, the practitioner proceeds to testing. As sequencing can affect the outcome, a specific order of testing is recommended **(Table 5)**.

EVALUATION OF SYMPTOMS

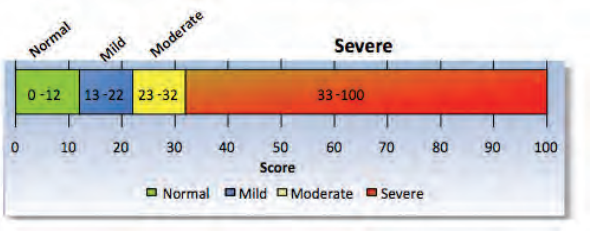
DED is largely a symptomatic disease.[27,28] As such, clinicians need validated tools to evaluate symptoms and appreciate how the daily lives of patients are affected. It is important to start the DED work-up with an assessment of symptoms, prior to instilling any drops or manipulating the eyes, in order to minimize the effect on the results.

Table 5. *Suggested order of dry eye disease work-up*

1.	Case history with dry eye questionnaire
2.	Osmolarity (if available)
3.	Tear quantity and volume Schirmer 1 (no anesthesia) or Phenol red thread test (PRTT)/Cotton thread test (CTT)
4.	Anterior segment evaluation with white light (focus on the lid margin)
5.	Tear break-up time (TBUT)
6.	Ocular surface integrity (using ophthalmic dyes and appropriate filters) Cornea Conjunctiva
7.	Meibomian gland (MG) expression and assessment
8.	Adjunctive tests *

**order of testing may vary as a result*

Figure 2. *Ocular Surface Disease Index (OSDI) severity scale.*



The Ocular Surface Disease Index (OSDI) [29] is a self-administered 12-question assessment of symptoms and how they affect vision-related tasks (i.e. reading, driving, computer use, etc.).[17] The questionnaire is divided into three sections: the first evaluates the frequency of symptoms; the second evaluates the effect of symptoms on daily tasks; and the third evaluates the effect of environmental factors, such as windy conditions and air conditioning. The scores on the three sections are summed to arrive at a final OSDI score, which ranges from 0 to 100, with higher values indicating greater symptom severity [normal (<12), mild (13-22) moderate (23-32) or severe (33-100), **Figure 2**]. The OSDI has a high degree of sensitivity (80%) and specificity (79%) for discriminating patients with and without DED, and is even better at identifying patients with severe disease (sensitivity 87%; specificity 96%).[17]

The OSDI is available in English and French, although only the English version has been validated. The French version has been professionally translated but not validated.[29]

The validated McMonnies questionnaire can be integrated into practice easily.[19, 30-32] Responses to questions about gender, age, medication use, general health and contact lens (CL) wear increase the suspicion for dryness and prompt the practitioner to perform further tests. Each response is assigned a numeric value and the sum is then compared to a risk table. The higher the total score, the greater the risk of dryness. The cut-off point for DED is 14.5 out of a possible 45.[33, 34] The questionnaire has a high sensitivity (98%) and specificity (97%) for DED, but is not as sensitive in categorizing marginal DED.

The DEQ-5 is a user-friendly questionnaire that is quick and easy to complete.[18] The patient rates the frequency (never, rarely, sometimes, frequent, and constant) with which they have experienced three symptoms (watery eyes, discomfort and dryness) in a typical month. The patient is also asked to rate the increase in intensity of discomfort and dryness throughout the day. Each response corresponds to a numeric value that is used to calculate a final DEQ-5 score. A DEQ-5 score >6 is indicative of DED and a score >12 is indicative of SS.

The SPEED questionnaire involves a series of four key DED symptoms that are rated on frequency and severity combined with 3 additional questions on artificial tear use, blepharitis and frequency of fluctuating vision.[20] The SPEED score is the sum of the Symptom and Frequency Scores, which range from 0 and 32. No cut-off value for DED has been adopted to date.[20]

Although several other validated DED questionnaires are available, some [DEQ, Impact of Dry Eye on Everyday Life (IDEEL)] are more suitable for research and will not be discussed here.[35, 36]

TEAR OSMOLARITY

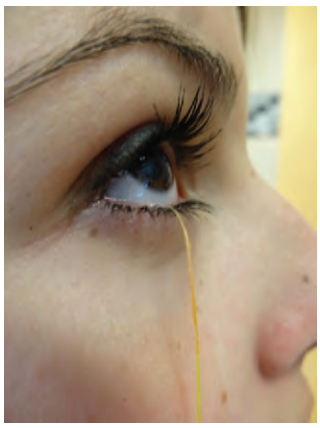
Tear osmolarity analysis is a point-of-care test that provides immediate results. A small sample of tears is obtained at the temporal edge of the tear meniscus with a TearLab pen. Once a 50 nL sample is obtained, the device beeps and a light indicates that the collection is complete. The pen is then placed into the reader and within 10 seconds the analysis is complete and the result is displayed in mOsmol/L.

Tear film osmolarity is the most accurate single test for DED,[8, 9] but should not be used in isolation for the diagnosis of DED. Generally readings higher than 308 mOsmol/L are considered diagnostic of DED. Higher values and a variance of >8 mOsmol/L between eyes indicate more severe disease.[8, 9]

EVALUATION OF TEAR FLOW

DEWS categorized DED as being primarily aqueous deficient or evaporative in origin.[10] Although the latter is more common, tear flow must be quantified to distinguish between these two categories. Measuring tear flow can assist in the initial diagnosis of DED and can be used to determine and monitor treatment options. Two readily available tests, the Schirmer test and the PRTT/CTT are useful in this regard.

Figure 3. *Phenol red thread test (PRTT)/Cotton thread test (CTT) placed in lower lid to measure residual tears.*



The Schirmer test has a reputation for causing discomfort, but is a sensitive test for detecting tear deficiency, particularly when SS is suspected.[37-40] When performed without anesthesia (Schirmer 1), the test measures the quantity of residual tears accumulating in the lower cul-de-sac during a 5 minute period. A value >10 mm/5 min is considered to be normal **(Table 6)**. Lower values indicate increasing degrees of tear deficiency. Care must be taken to avoid stimulating reflex tearing, which renders the result inconclusive for most cases of DED. The test is more robust in tear-deficient DED, in which the patient is incapable of producing adequate tears.[7] The sensitivity (85%) and specificity (83%) of the Schirmer test are relatively high for differentiating between normal individuals and those with tear deficiency.[41]

The PRTT is a fast and more comfortable alternative test for assessing tear volume. It is performed by inserting a phenol red-impregnated cotton thread in the lower fornix of the lid for 15 seconds **(Figure 3)**.[42-45] The change in colour of the wetted thread is easy to observe and measure directly with the scale on the package. A value >9 mm/15 sec is considered to be normal **(Table 6)**. The sensitivity (86%) and specificity (83%) are comparable to that of the Schirmer test (see above).[15] As with any measure of tear quantity, the clinician needs to be aware of high readings as these may be suggestive of reflex tearing.

There are more sophisticated ways of quantifying the lower tear meniscus height (TMH) as an indirect measure of tear volume (e.g., anterior optical coherence tomography (OCT) or corneal topography). Although these tests are generally not available to most clinicians, they are gaining acceptance.[46-50]

Figure 4. *Mastrota paddle used to express the meibomian glands.*

Figure 5. *Meibomian Gland Evaluator (TearScience) used to express the meibomian glands with a consistent force.*

ANTERIOR SEGMENT EVALUATION

A systematic assessment of the lashes, lid margin, cornea, and bulbar and palpebral conjunctiva is needed to assess the proper functioning of the tear film and ocular surface.

Particular attention is given to the lid margin where evidence of blepharitis (anterior or posterior), lash loss (madarosis), thickening of the lid margin (tylosis), lid inapposition, notching of the lid margin, posterior migration of gland orifices, and dilation of small blood vessels along the lid margin (telangiectasia) can be observed. Debris accumulated on the lashes, whether from make-up, environmental contaminants or from anterior blepharitis, can fall onto the tear film, increasing the viscosity and slowing the movement of the tear film towards the punctum.

EVALUATION OF MEIBOMIAN GLANDS

Expressing the MG and evaluating the composition of their secretions is important.[51] Assessing the MG can provide insight into the factors contributing to evaporative DED. The appearance and consistency of meibum expressed by the Mastrota paddle, the Meibomian Gland Evaluator or simply by a finger or cotton swab, can be described in terms that correspond to increasing levels of MGD (clear, cloudy, cloudy with debris, thick or paste-like, or non-expressive).[51] Saponification, or the appearance of bubbles similar to a soap foam (frothing) along the lid margin, can indicate hypersecretion of the MG.[52] The foam often accumulates in the temporal canthus and is easily observed using a slit lamp.

Tools such as the Mastrota paddle[54-56] and the Meibomian Gland Evaluator (TearScience)[55, 56] have been developed to assist in MG expression, although using the thumb to press on the lid or a wet cotton swab behind the eyelid are effective alternatives.

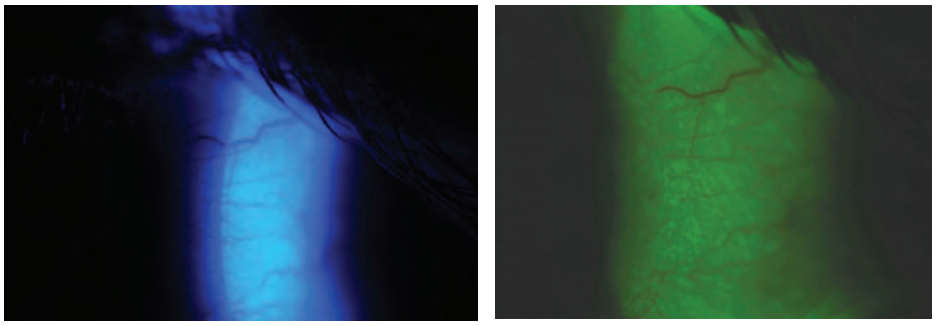
The Mastrota paddle (available from Ocusoft) is a 7 cm titanium instrument with rounded edges that is placed behind the lower lid to assist in the expression of the MG **(Figure 4)**. Using a finger or thumb, gentle pressure is applied to the lower central to nasal lid to express the MG against the surface of the paddle.

The Meibomian Gland Evaluator looks like a USB key **(Figure 5)**. The white tip is pressed tangentially against the central lower lid to exert pressure equivalent to that of a normal blink (i.e.. between 0.8 and 1.2 g/mm^2) and then is retracted into the blue housing.[57]

EVALUATION OF OCULAR SURFACE INTEGRITY

The evaluation of the integrity of the ocular surface, cornea and conjunctiva is an essential part of the DED workup. Fluorescein is best suited for assessing the cornea, while lissamine green (LG) is preferred for the conjunctiva.[58, 59] The use of both ophthalmic dyes is optimal to ensure adequate evaluation of ocular surface integrity. LG has a robust safety profile,[60] and is better tolerated than rose bengal, which stings on instillation;[61] however, obtaining LG is a challenge in Canada and the U.S.

Figure 6. *Conjunctival tissue observed under cobalt blue illumination (left) and enhanced with a yellow barrier filter (right).*



Staining of the cornea and conjunctiva indicates that the integrity of the tissue has been compromised and that inflammatory mediators are present.[10, 62] Many factors can cause corneal staining including prolonged surface exposure due to infrequent or incomplete blinking,[63, 64] toxic effects of preservatives in eye drops,[65, 66] CL wear and exposure to CL care solutions,[67-70] and lid margin inflammation caused by blepharitis. A thorough case history that includes systemic and ocular medication use, and the type of CL and cleaning solutions used, will tease out some of the factors responsible for the breakdown in ocular surface integrity. Whatever the cause, or the ophthalmic dye used, proper documentation of staining should include the pattern, position, depth and the grade (identifying the scale that is used).[71]

Overall, corneal staining in non-CL wearers occurs more frequently in the inferior quadrant, with the central cornea being affected least.[72] When adding fluorescein it is important to control the instilled volume. If the strip delivers too much dye, quenching can occur and it may be difficult to see any pattern until the excess is cleared from the eye. Controlling the volume (by shaking off the excess prior to instillation) and having the patient blink several times to distribute the fluorescein should optimize the assessment.[73] Adding a yellow barrier filter enhances subtle staining and is essential to use to assess conjunctival fluorescein staining **(Figure 6)**. Most new biomicroscopes have an integrated barrier filter. Otherwise, a hand held filter may be used.

Identifying the pattern and location of staining provides clues to the cause of the symptoms. Staining may occur as scattered superficial dots (punctate staining), or coalesce to form patchy or confluent areas. These patterns may be located in any quadrant of the cornea (superior, inferior, temporal or nasal) or may even be interpalpebral. Staining in the superior quadrant is indicative of superior limbic keratoconjunctivitis (SLK), a condition found mostly in women aged 20-60 that is believed to be related to a tight lid/globe interface or thyroid disease. Diffuse punctate staining across the cornea may be indicative of toxicity. Reviewing the preservatives in eye drops or CL care solutions may reveal the cause of the observed fluorescein hyperfluorescence, which

Figure 7. *Distinguishing the difference between solution-induced corneal staining (SICS) (on the left), and DED staining (on the right)*

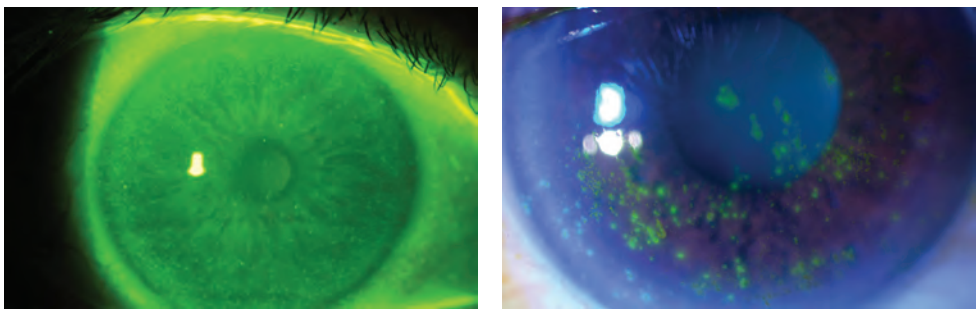


Figure 8. *Lid wiper epitheliopathy (LWE) observed below the meibomian gland openings in the upper everted eyelid of patient's left eye.*

is known as solution-induced corneal staining (SICS) and should not be confused with diffuse superficial punctate keratitis (SPK) **(Figure 7)**. SICS is not considered to be true staining but, rather, is associated with increased permeability of epithelial cell membranes after exposure to preservatives. It is not associated with a higher infection rate. The presence of the transitory SICS in soft CL wearers should prompt the clinician to review the compatibility of the CL and the solutions.[67] It is highly recommended to consider a refit into daily disposables at that time.

Corneal staining near the lid margin (superior or inferior) points to blepharitis. Careful assessment of the lashes and lid margins is essential to determine the source of this staining pattern. Staining between the lid margins (interpalpebral) points to an incomplete or ineffective blink, or to nocturnal lagophthalmos, conditions that leave the cornea exposed to dehydration. Sectoral staining may be caused by a foreign body or a localized irritant, such as GPC, concretions, a loose lash or debris.

Conjunctival bulbar staining also provides insight into the etiology of DED. Both fluorescein and LG can be used to assess the conjunctiva, although LG is more sensitive, especially for symptomatic CL wearers.[59] Staining occurs more frequently on the nasal conjunctiva in patients with DED, whereas temporal staining is more indicative of SS.[74] These new clinical findings reinforce the use of ophthalmic dyes in a comprehensive DED workup in assessing the integrity of both the cornea and conjunctiva.

Some practitioners advocate simultaneous double staining of the ocular surface with both fluorescein and LG as a way to save chair time. Double staining correlates well with symptoms and tear film stability in patients with DED. Typically, the nasal conjunctiva stains to a greater extent than the temporal conjunctiva, with the cornea being affected less. To date, there are no commercially available combination dyes in Canada.

The clinician's attention should also be directed to the inner lid margin, above the Marx line, to an area called the "lid wiper". The lid wiper is that part of the inner upper palpebral conjunctiva that is in contact with the cornea during a blink.[76] This area stains with both fluorescein and LG, and lid wiper epitheliopathy (LWE), or upper lid margin staining (ULMS), as it is also termed,[77] may be present in symptomatic patients, more often in CL wearers,[78] despite a normal TBUT **(Figure 8)**. The presence and intensity of the LWE may be related to decreased mucin production, more specifically mucin-5AC, in symptomatic CL wearers.[79, 80]

To view LWE, the upper lid is everted to expose the area under the opening of the MG. It has been suggested that instilling dye from two strips of LG 1 minute apart then waiting for at least 3 minutes optimizes the viewing of LWE.[81] LWE can be graded, and its progress monitored, by measuring the thickness and length (in mm) of the stained area.

EVALUATION OF TEAR FILM STABILITY

Once fluorescein has been instilled to evaluate tissue integrity, the stability of the tear film can also be assessed. The tear break-up time (TBUT), probably the most familiar test for this

purpose, is defined as the time (in seconds) needed for the first break or rupture in the tear film after a blink. Despite its long history of use, the results are often highly variable and many practitioners have lost confidence in the test. However, the variability can be reduced by adhering to a standardized method, which includes wetting the fluorescein strip with sterile saline, controlling the volume instilled (by shaking off excess), tapping the lower tarsal conjunctival surface (as opposed to bulbar) and delivering only a small volume.[73, 82] The clinical value of the TBUT can be further improved by calculating the average of two consecutive measurements.[7]

A TBUT of more than 10 seconds is indicative of a stable tear film. In contrast, patients with DED tend to have a rapid TBUT, typically <5 seconds. Ethnic differences exist, mainly due to differing lid morphologies, such as those in Asian patients, in whom the TBUT is often shorter.[83, 84]

Fluorescein can reduce tear film stability,[85] and less invasive methods are available for the measurement of TBUT. The non-invasive break-up time (NIBUT) can be measured by using the reflected mires of a corneal topographer or other instrument. These methods generally yield longer break-up times.[86-89]

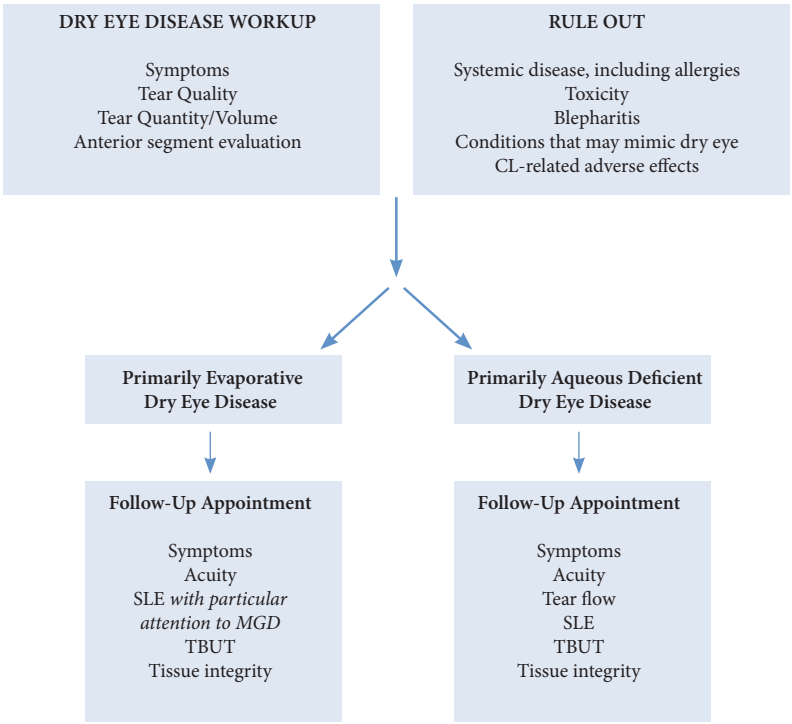
Normal values expected in a comprehensive DED workup are summarized in **Table 6**. Additional tests can be performed, depending on the case, the availability of equipment and the expected clinical value. A description of adjunctive tests and some emerging technologies is provided in the **Supplementary Appendix.**

Table 6. *Normal values for dry eye disease testing*

Evaluation	Test	Normal values
Symptom questionnaire	OSDI	<12 /100
	McMonnies	<14.5/45
	DEQ-5	<6 for dry eye
Tear volume	Schirmer	>10 mm/5 min
	PRTT	>9 mm/15 sec
Tear osmolarity	TearLab Osmometer	<308 mOsml/L
Anterior segment evaluation	Slit Lamp examination	
Tear film	Viscosity	Medium-fast
	Debris	Little to none
Lashes	Lashes	No debris, collarettes or dandruff cuff
Meibomian glands	Expression	Easy
	Secretions	Clear, liquid
Lid margin	Lid margin	Good apposition, smooth
Tear film stability	FL-TBUT	>10 sec
	NIBUT	> FL-TBUT
Tissue integrity (using ophthalmic dyes)	Cornea Conjunctiva	No staining to trace staining (<grade 2)

Figure 9 summarizes the recommendations in this section to help guide the clinician in the management of dry eye disease patients.

Figure 9. *Summary of Full DED workup.*



GENERAL PRINCIPLES OF MANAGEMENT: OVERVIEW AND CLASSIFICATION

A practical, clinician-friendly approach is proposed whereby patients with DED are categorized as having "episodic" or "chronic" disease at their initial visit. A third category, "recalcitrant", is reserved for patients who do not respond sufficiently to the available battery of treatment options and, therefore, require more intensive therapies including systemic medications or surgery. **(Table 7)**

The overarching principle in the management of patients with DED is to reduce symptoms and return the tear film and the ocular surface to as close as possible to a normal state of health. While this may be achieved in patients with episodic or mild disease, it is more challenging in patients with chronic DED, in whom moderate or severe symptoms and signs are more common.

Episodic disease occurs when symptoms and signs are not consistently noted; that is, they are present only under certain environmental conditions or during specific visual tasks. Patients with episodic disease may report varying levels of symptom severity, but experience symptoms only when situations such as reduced blinking, CL wear or environmental conditions overwhelm the stability of the tear film or homeostasis of the ocular surface. Episodic disease may result from tear flow deficiencies and/or tear evaporation, but in either case the effects are transient.

DED that is not episodic must be, by definition, **chronic** in nature. The unifying mechanism

in chronic DED is presumed to be consistent inflammation. Chronic DED is also influenced by environmental conditions, and symptoms and signs continue to vary in severity. While the recommended therapies for episodic disease are used concurrently, the focus in chronic DED is on controlling the inflammatory mediators to reduce symptoms and signs, and to minimize disease progression.

Recalcitrant DED applies to those patients in whom primary interventions have proved to be insufficient and in whom additional and/or uncommon ("rescue") strategies may be required. This may occur when, despite maximal application of conventional therapies, a patient remains symptomatic, or the effects to vision and/or tissue damage on the ocular surface progresses to the point where the risk of more serious sequelae is significant. These uncommon interventions may include unique devices (e.g. scleral lenses, amniotic membranes), specialized medications (e.g. autologous serum eye drops, secretagogues), or surgery (e.g. tarsorrhaphy), that are not normally available to the primary eye care practitioner.

TREATMENT FOR EPISODIC DISEASE

The management strategies for episodic DED target the presenting symptoms, and attempt to control the exacerbating external conditions. The history and diagnostic workup will often reveal early stages of disease, and management is focused on removing or limiting the environmental cause. The practitioner is advised to use the most appropriate treatment, and to educate each patient not only about the treatment, but also about the rationale for its application.

MANAGEMENT OF DRY EYE DISEASE

Table 7. *A novel clinical classification and management strategies in DED*

TYPE	MANAGEMENT	
EPISODIC	Tear supplements / lubricants	*Consider composition of available agents (lipid-based, products that restore the mucin layer, overall)*
	Ocular	*Hot compresses, lid hygiene, moisture chamber glasses, modifications to CL wear (switch to daily disposables)*
	Non-ocular considerations	*Environmental (ambient humidity, air movement, computer use), systemic medications and supplements, alcohol, smoking, hormonal status, sleep apnea*
CHRONIC		**Episodic management** +
	Short-term	*Topical corticosteroid*
	Long-term	*Topical cyclosporine* *Essential fatty acids*
	Supportive	*Oral tetracycline / macrolide, lacrimal occlusion, meibomian gland (MG) expression (in-office), sleep masks/lid taping*
RECALCITRANT	Ocular	*Scleral lenses, filament removal, autologous serum eye drops, amniotic membranes, tarsorrhaphy, other surgical techniques*
	Systemic	*Secretagogue, systemic immunosuppressive therapies*

TEAR SUPPLEMENTATION

Tear supplements or lubricants are the mainstay of treatment across the full spectrum of DED. There is evidence to show that the use of tear supplements is beneficial to the ocular surface. For example, ocular surface staining with rose bengal improves by 25-33% within one month of using tears, gels or hyaluronate-based supplements.[90] There are many different active ingredients and formulations of tear supplements, the most relevant of which are described in **Table 8**. Evidence and clinical wisdom will guide the clinician as to the product and frequency of use to recommend for a given patient. However, the use of ocular lubricants more than 4 times a day should prompt the clinician to recommend a non-preserved product to reduce the

risk of toxic adverse effects on the ocular surface. Preservative-free products should also be favored in the presence of other ocular topical medications.

Tear supplements lubricate, can promote ocular surface cell health and may alter the inflammatory state of the ocular surface. They do so indirectly by affecting the tear film osmolarity and, possibly, by decreasing the concentration of inflammatory mediators in the tear film, but do not specifically target the underlying inflammatory disease associated with chronic DED. Because of this, tear supplements are valuable adjunctive therapies when using anti-inflammatory therapies to treat DED. Properties of tear supplements that are important for relieving symptoms and promoting ocular surface healing include: osmolarity, the presence of and type of preservative, inclusion of polymers to increase retention time, and lipid composition **(Table 8)**.[90-92]

Table 8. *Considerations when selecting a tear supplement for a patient with dry eye disease*

Property	Consideration for Tear Supplements	Recommended examples
Osmolarity	Should ideally shift tear osmolarity from a hyperosmolar to an isotonic state over time	Blink®, HYLO®, Hypotears®, Refresh Optive Advanced®, Theratears®
Preservatives (multidose formulations)	If preserved products are to be used, avoid benzalkonium chloride (BAK) and choose those that contain Polyquad, Purite or sodium perborate	Genteal®, Refresh® (Purite) Tears Naturale II® (Polyquad), Theratears® (sodium perborate)
Preservative-free (most are unit-dose)	Preservative-free products are preferred, especially as frequency of use increases or in the presence of other topical medications	Bion Tears®, HYLO, HYLO-gel® I-Drop®, I-Drop® PM, I-Drop® Pur Gel®, Refresh Celluvisc®, Refresh Endura®, Refresh Optive Advanced® Sensitive, Refresh Plus®, Systane® Ultra PF, Tears Natural Free®, Theratears® PF
Polymers and viscosity	Enhance hydration of the mucin-gel of the tear film and increase retention time of tear supplements Consider use of low viscosity products (drops, gels) during the day and more viscous products (ointments) during the night	Carboxymethylcellulose, sodium hyaluronate, hydroxypropyl guar-borate
Lipid Content	Oil-based emulsions restore the inadequate lipid layer in patients with MGD and DED	Liposic®, Refresh Endura®, Refresh Optive Advanced®, Refresh Ultra®, Systane® Balance
Sodium hyaluronate-containing products	For LWE issues	Blink®, Hyabak®, HYLO®, I-Drop®

OCULAR CONSIDERATIONS

A number of simple measures can be recommended to relieve the symptoms and signs of DED. These include hot compresses, lid hygiene (when indicated), moisture chamber spectacles and modification of existing CL wear.

Hot Compresses

Hot compresses are a mainstay of the management of DED associated with MGD. The melting point of the lipid secretions of patients with MGD is elevated compared to those of patients without MGD (from 32 to 35 °C). Tear film lipid layer thickness increased by more than 80% in patients with obstructive MGD after application of a 40 °C compress for at least 4 minutes, and improved by a further 20% after 15 minutes of treatment.[93] While hot compresses are often recommended and may improve secretion from accessory tear glands, their method of use is not standardized. Usually, it is recommended that hot compresses be used on a daily basis for a few weeks or months then, to establish a maintenance regimen, 2 to 3 times a week, depending on the degree of improvement in the condition. Unfortunately, effective use of hot compresses is time intensive and patients find it difficult to maintain a consistent daily regimen

with traditional methods such as a face cloth.[94] Alternate products such as MGDRx EyeBag , Bausch & Lomb Thera Pearl® , Thermoeyes goggles and the Bruder Eye Hydrating Compress are effective devices that help patients adhere to a regimen. Lipiflow® is an expensive in-office treatment that can be recommended for recalcitrant or non-compliant patients, but also as a primary therapy.

Lid Hygiene

Lid hygiene is generally recommended for patients with anterior blepharitis, and despite the number of products available (i.e., TheraLid™, Systane™ Lid wipes, and I-Lid n' Lash®), procedures for use have not been standardized. It is important that patients understand how to gently cleanse their lids and lashes and how to prevent the product from contacting and irritating the ocular surface. Products used for lid hygiene contain many components, some of which may not be listed on the label. Recently, products with tea tree oil have been recommended for blepharitis related to *Demodex folliculorum* (a parasitic mite). For example, shampoos, facial hygiene products, lid wipes (i.e. Cliradex) and solutions are being formulated in higher concentrations for in-office treatment of *Demodex* lid infestations..

Moisture Chamber Spectacles

Moisture chamber spectacles are a highly effective but underutilized option for increasing ambient humidity and minimizing the impact of environmental conditions on the ocular surface. Patients often start by wearing a pair of sunglasses to reduce symptoms in outdoor environments. If this is effective, they should be encouraged to use clear moisture chamber glasses indoors and outdoors in low light situations. A number of brands are available that allow for the incorporation of patients' prescriptions; however, a good fit is critical to achieving comfort and success.

NONOCULAR CONSIDERATIONS

There are a host of non-ocular factors that contribute in varying degrees to the symptoms and signs of DED. Although many of these factors are non-modifiable, they are worth considering in order to educate patients on the role they play in the disease.

Ambient humidity, air movement and the use of computers and hand-held devices, are all important factors in DED. Maintenance of high ambient humidity is a critical step in the environmental modifications that can help patients to cope with tear evaporation. The use of small humidifiers in the office or home can improve symptoms dramatically. This strategy is especially useful in climates where air conditioning or heating are used for extended periods. Air movement by fans or wind is harmful to the fragile tear film and ocular surface, and could be protected against with moisture chamber goggles, or at the very least, by spectacles. Airplane and car travel are particularly bothersome and damaging. Ocular allergies may cause or exacerbate DED and use of oral antihistamines may further dry the tear film and worsen symptoms.[95]

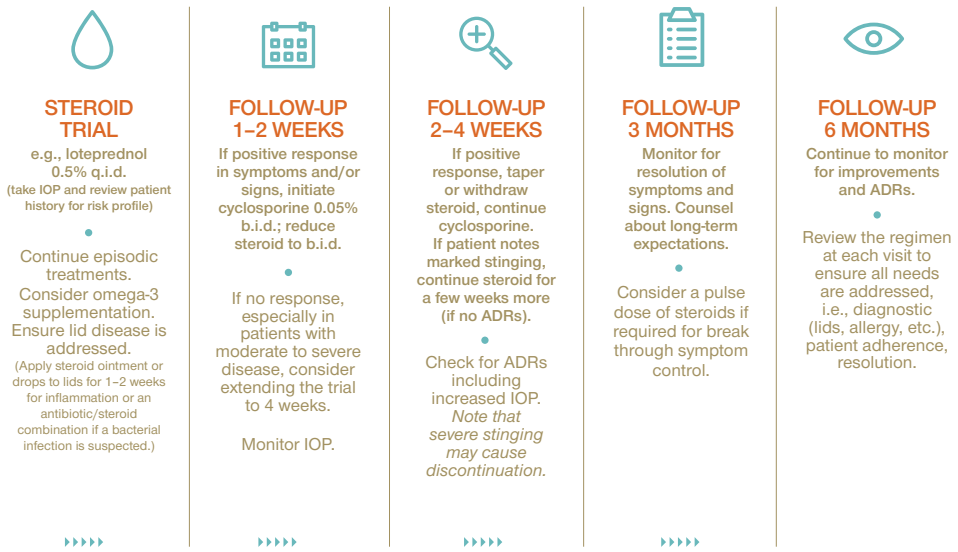
A large number of systemic medications have drying effects on the mucous membranes of the eyes (e.g. antihistamines, anti-depressants, diuretics **[Table 2]**). While these can be discussed with the patient and prescriber, essential medications will not normally be discontinued due to DED. Consumption of alcohol and exposure to cigarette smoke are environmental triggers that should be avoided.

Androgen/estrogen imbalance contributes to DED. Women are more affected than men. While clinical trials of both androgen and estrogen eye drops are ongoing, some patients may benefit from topical hormone therapies.[91]

Continuous positive airway pressure (CPAP) for sleep apnea may exacerbate morning DED symptoms due to forced air escaping from poorly fitting masks. A flexible shield (Quartz) has been developed to protect the eyes while not affecting the fit of the CPAP mask.

The use of computers and hand-held devices is associated with episodic symptoms and exacerbations of chronic DED. It is important to evaluate time spent on these devices, blink

Figure 10. *Management of chronic dry eye disease.*



rate and completeness, and the role of CL wear. Computer workstations should be modified to ensure that screens are placed below the primary line of sight in order to minimize lid aperture width and subsequent tear evaporation.

MANAGEMENT OF CHRONIC DISEASE

Even with the diligent use of conventional (episodic) treatments (e.g. tear supplements, hot compresses), many patients with DED experience progression of symptoms and/or ocular surface signs. This is due, at least in part, to ageing, as all measures of tear function decline with age;[96] however, the lack of targeted anti-inflammatory therapy, poor adherence and underlying chronic systemic diseases may also contribute to progression.

An abundance of research in the last decade has prompted a shift in thinking about DED. A self-perpetuating cycle is occurring on the ocular surface, whereby abnormal tear secretion alters the tear film composition and, in turn, increases tear film osmolarity. Increased tear film osmolarity stimulates the production of inflammatory mediators on the ocular surface, which causes the malfunction or destruction of cells that secrete various components of the tears.[10]

As inflammation is the core mechanism responsible for chronic DED regardless of the cause, strategies aimed at arresting the cycle of inflammation are pivotal in healing the ocular surface, reducing symptoms and minimizing disease progression.[97]Anti-inflammatory treatment involves a trial of a topical corticosteroid, which, if tolerated and successful, is followed by long-term immunomodulatory therapy. Regardless of the episodic treatment recommendations, anti-inflammatory therapy is at the forefront of the treatment paradigm for chronic disease. Breaking the cycle of inflammation early in the course of the disease may prevent the need for more substantial interventions as the patient ages.

SHORT-TERM ANTI-INFLAMMATORY TREATMENT

Corticosteroids

Corticosteroids are effective in relieving the symptoms and signs of chronic DED.[62, 98-100] As soon as the patient's condition is identified as anything but episodic, a steroid trial should be initiated (subject to the usual cautions and contraindications). Not only are corticosteroids helpful to gauge the efficacy of anti-inflammatory therapy in an individual patient, but they are also used to ease a patient into long-term anti-inflammatory treatment options, primarily topical cyclosporine **(Figure 10)**.

Specific signs and symptoms that might prompt the use of corticosteroids include ocular surface discomfort, obvious inflammation of the lids and ocular surface, corneal staining, low tear production, and inadequate relief of symptoms with hot compress and tear supplements. It is imperative to consider corticosteroid therapy when the conjunctiva and cornea show consistent signs of ocular dryness (e.g., by fluorescein or LG staining). However, long-term use is limited due to adverse effects such as cataracts, immunosuppression, and the potential for increased intraocular pressure (IOP).[101]

While many topical corticosteroids have been evaluated and are effective,[62] the most obvious one to consider is loteprednol etabonate 0.5% (Lotemax®), due to its similar efficacy, and superior safety profile compared to the most potent ketone-based topical corticosteroids.[102] Loteprednol is less likely to cause an IOP spike, cataracts or delayed tissue healing than other similarly effective steroids.[98, 99]

If a patient is unable to tolerate loteprednol, a preservative-free formulation should be considered. Methylprednisolone acetate 1% has shown favourable results in DED associated with SS, with all patients experiencing improvement in symptoms and signs within 8 weeks when used up to four times per day. Of note, improvement (measured by impression cytology) lasted an average of 56.6 weeks after a first pulse, and even longer after a second.[103] This type of non-site-specific steroid has the potential to cause a significant increase in IOP and steroid-induced glaucoma, cataracts, as well as other adverse effects. For these reasons, these agents are generally reserved for patients in whom loteprednol cannot be used. Regardless of the corticosteroid product that is prescribed, the clinician should establish an appropriate follow-up schedule for each patient.

Generally, when inflammation is considered to be present in DED, loteprednol 0.5% is administered q.i.d and continued for 2 to 4 weeks, or sometimes longer, during which time efficacy, IOP and side effects are evaluated. If symptoms or signs improve, then treatment with cyclosporine 0.05% (Restasis®) may be initiated. Barring any complications, the corticosteroid is continued concurrently at a reduced frequency with the cyclosporine for another 2 to 4 weeks to mitigate the transition to monotherapy with cyclosporine **(Figure 10)**.

If inflammation of the lids is apparent, application of a topical corticosteroid ointment such as dexamethasone 0.1%, or loteprednol 0.5% is appropriate and may precede use of loteprednol drops. Alternatively, use of an antibiotic-steroid combination product may be considered (e.g., tobramycin 0.3%/dexamethasone 0.1% (Tobradex®), neomycin 0.35%/polymyxin B/dexamethasone (Maxitrol®).

Non-steroidal anti-inflammatory drugs

Non-steroidal anti-inflammatory drugs (NSAIDs) have a limited role in the management of DED. Their main use is to reduce or eliminate the pain and abnormal membrane-bound mucin layer associated with filamentary keratitis.[104, 105]However, this may also be accomplished with corticosteroids. Topical NSAIDs, especially generic versions, must be used with caution as corneal melting has been associated with chronic use after surgery and in patients with uncontrolled autoimmune disease.[106]

LONG-TERM ANTI-INFLAMMATORY TREATMENT

Topical cyclosporine

Topical ophthalmic cyclosporine 0.05% (Restasis®) formulated with castor oil as an emulsion vehicle is an effective and safe treatment for chronic inflammation on the ocular surface. Cyclosporine modulates T-cell-mediated inflammation and, although some patients may report symptomatic improvement in as little as a couple of weeks, it may take 3 months or longer to show a demonstrable effect in symptoms or signs.

The use of this drug is evolving. The original approval for topical cyclosporine was based on an increase in tear flow. Treatment with topical cyclosporine is commonly used in moderate to severe DED but it has been shown to prevent progression in patients with milder forms of

DED.[97] Cyclosporine is also useful for the long-term treatment of MGD.[107] Indeed, long-term treatment with cyclosporine outperformed a combination of tobramycin/dexamethasone in patients with posterior blepharitis.[108]

Before initiating treatment with cyclosporine, it is important to discuss the course of the treatment in order to manage patient expectations. While improvement in signs and symptoms can be seen within the first 8-12 weeks of treatment, patients with severe chronic or recalcitrant disease can take up to a full year to experience improvement. It is important to use the treatment long enough to evaluate the condition properly and to encourage adherence at follow-up visits. Photodocumentation can help a patient to understand small and subtle changes in their ocular condition, and is helpful to increase treatment adherence. Clinical positive outcomes can be noted earlier if an anti-inflammatory treatment is instituted before application of cyclosporine.

The main adverse effect noted with cyclosporine is burning on instillation, which was experienced by 17% of subjects in a clinical trial (10% higher than that associated vehicle alone).[109] Cyclosporine is not associated with steroid-induced ocular adverse effects, and given the need for long-term therapy in chronic DED, the long-term safety profile is one of the key benefits of cyclosporine.[110]

Essential fatty acids

The role of essential fatty acid (EFA) supplementation in the treatment of DED is evolving. However, clinical recommendations vary because the most effective form of EFA and the optimal dosing regimen is yet to be determined.

EFAs, such as omega-3 fatty acids, are essential nutrients that must be acquired in the diet. They include docosahexaenoic acid (DHA) and eicosapentaenoic acid (EPA), which are found in cold-water fish such as mackerel, anchovies, sardines, albacore tuna, and salmon, and alpha-linolenic acid (ALA), which is found in plant sources such as flaxseed, for example, but must be converted to EPA and DHA to be used by the human body.

Gamma-linolenic acid (GLA) is an omega-6 EFA with anti-inflammatory properties that is found in black currant seed oil, evening primrose oil and to a lesser extent borage oil. GLA must be combined with EPA/DHA at a minimum ratio of 1:1, otherwise there is a risk that it will have proinflammatory effects. In the presence of EPA/DHA, GLA has been shown to have significant anti-inflammatory properties and to be effective in DED with an inflammatory component.[111, 112] GLA has been shown to be useful in the management of CL-associated DED,[113] KCS associated with SS,[114] and post refractive surgery DED.[115] Moreover, GLA has been shown to improve signs and symptoms of moderate to severe KCS with inflammatory components,[116, 117] and DED associated with MGD.[118]

While the best form and optimum dose of EFA continues to be debated, it is clear that these compounds have anti-inflammatory effects, and are helpful for the treatment of DED.[119-121]

ADJUNCTIVE TREATMENTS

In addition to corticosteroids and topical cyclosporine, a number of other treatments with anti-inflammatory properties are available for the treatment of DED, but are not recommended in all patients. Those listed in this section are indicated when certain lid diseases, specifically MGD with or without rosacea, are a significant component of DED.

Oral tetracyclines/macrolides

Tetracyclines are used extensively in the treatment of MGD and ocular and facial rosacea. Oral macrolides may be considered when tetracyclines are contraindicated, or in the event of unacceptable adverse reactions. More recently, a topical macrolide, azithromycin, has been developed.[122]

Tetracyclines (tetracycline, doxycycline and minocycline) have properties that are useful in

the management of DED. In addition to their antibacterial properties, these drugs also inhibit bacterial lipases, thereby reducing production of free-fatty acids in the lipid component of MG secretions and the tear film.[91] They also have anti-inflammatory properties, including inhibition of matrix metalloproteinases (MMP), phospholipase A2, and collagenase. The anti-inflammatory effects can also prevent the development of new blood vessel formation (corneal neovascularization) in rosacea.

The most commonly used tetracycline in eye care is doxycycline, which may be given at a dose of 40 or 50 mg once daily for MGD.

Patients with contraindications to tetracyclines, including children and pregnant or nursing women, may benefit from a course of an oral macrolide antibiotic, such as erythromycin or azithromycin, although the dosage and time course have not been well studied.[123, 124]

Lacrimal occlusion

Tear retention by lacrimal occlusion decreases symptoms, reduces corneal staining, prolongs TBUT, increases goblet cell density and decreases tear film osmolarity.[125, 126]

It is intuitive to consider lacrimal occlusion in patients with aqueous deficiency. Consider lacrimal occlusion for patients with <15 mm of wetting, and especially for patients with <10 mm wetting on the PRTT/CTT.

Control of inflammation is an important consideration. Impaired tear drainage may prolong the contact of pro-inflammatory mediators with the ocular surface. Conversely, tear film osmolarity may decrease and attenuate the inflammatory cascade. Normally, MGD and ocular surface inflammation should be controlled by a course of anti-inflammatory treatment before lacrimal occlusion is undertaken. However, this may be challenged in cases of severe aqueous deficiency (e.g. PRTT < 5 mm), when lacrimal occlusion is required to facilitate tear retention earlier in the course of treatment of a very dry eye.

Lacrimal occlusion is also indicated in CL intolerance, filamentary keratitis, neurotrophic corneae (with or without keratitis), cranial nerve VII (CN7) palsies and systemic diseases such as SS, Stevens-Johnson syndrome, graft versus host disease (GVHD), and others.

For patients with an occluded canaliculus, active canaliculitis, allergies to the materials, or frank punctal ectropion, lacrimal occlusion is contraindicated.

The most common complication is spontaneous extrusion of the plug(s) which necessitates replacement. Other complications include internal migration of punctal plugs, the inability to irrigate intracanalicular plugs, and pyogenic granuloma formation.[125, 126]

Meibomian gland expression

Although MG expression is a diagnostic procedure that reveals the quality and quantity of secretions (see previous section), it is also a therapeutic procedure that promotes normal gland function. Techniques include simple application of pressure to the lid[127] or placement of a metal object (e.g. Mastrota paddle) behind the lid to reduce pressure on the globe.

A novel thermal pulsation system for MG expression is available (LipiFlow®). The system heats the MG and expresses their secretions using a pulsatile inflatable cup. Symptoms and some objective signs (MG secretions, corneal staining and TBUT) improve with a single treatment and may be maintained for up to 9 to 12 months.[128] Further study is needed to determine the outcomes of single and repeated treatments.

Sleep masks and lid taping

Patients in whom lid closure is inadequate, especially during sleep, may benefit from lid taping, night-time masks or patches. Patients must be instructed on proper technique to protect the vulnerable ocular surface from trauma.

MANAGEMENT OF RECALCITRANT DISEASE

Ocular

Scleral contact lenses

Traditional contact lenses are generally avoided in patients with severe DED disease, except to act as bandage lenses for patients with a high degree of corneal staining.[129] However, scleral lenses, commonly used for treatment of an irregular cornea, may also be used for treatment of severe DED, including SS, neurotrophic keratitis and other surface disorders. A number of different lenses, including scleral lenses, have been used to treat patients with SS, irregular astigmatism, exposure keratitis, and other ocular surface conditions.[130, 131] All types of scleral lenses are designed to protect and heal the ocular surface, and to improve vision. They are suitable in addition to standard treatments.

Materials that allow high oxygen delivery and a limited amount of clearance under the lens are required in order to promote corneal and conjunctival metabolism, especially in the presence of altered endothelial cells. Patients with severe disease benefit from large diameter lenses (18-20 mm) while those with less severe disease may use mini-scleral lenses (14.5 to 16 mm), which are easier to fit and to handle.[132]

Topical medications, including anti-inflammatories, can be used concomitantly with scleral lenses. Scleral lenses are available in designs made for regular corneae as well and can be used to address episodic eye dryness related to contact lens wear. Well fitted scleral lenses may provide the same comfort as soft lenses, and provide the same quality of vision as gas permeable lenses, but offer the unique advantage of preserving hydration over time.[133, 134] By bathing the cornea on a constant basis, they can help to improve the patient's comfort and alleviate end-of-the day dryness.

Autologous serum eye drops

Autologous serum eye drops are made from the liquid component of the patient's own blood and contain a number of components found in natural tears that are involved in maintenance of the ocular surface, such as epidermal growth factor, transforming growth factor B, fibronectin, vitamin A and cytokines.[135]

Autologous serum eye drops are generally reserved for patients with severe disease whose treatment options have been exhausted. This is due, in part, to cost, but also to the lack of regulatory standards for serum preparation and storage, and to a paucity of data on which to standardize indications, to establish risks and contraindications, and to guide patient selection.[136] There are few centres that offer this therapy, and those that do are generally located in teaching hospitals. Autologous serum eye drops promote healing of the cornea with few adverse effects; however, the preparation, concentration (20%, 50%), and dosing frequency and duration are not standardized.

Amniotic membrane transplants

Sutureless amniotic membrane transplants (ProKera®, Biotissue) are an option for patients with severe recalcitrant DED and other ocular surface disorders. The device consists of a piece of amniotic tissue held in place by two clear, flexible rings. Healing of corneal lesions has been reported in 44 to 70% of patients depending on the indication.[137, 138] Some patients experience discomfort after placement of the device and recurrence of the primary pathological condition.

Tarsorrhaphy

Tarsorrhaphy may be a temporary or permanent procedure used to narrow the palpebral fissure in patients with non-healing ocular lesions associated with corneal exposure, severe dryness and loss of corneal sensitivity. Graves disease and CN7 palsies are examples of conditions that can cause extreme corneal exposure. Severe dryness may occur with or without systemic disease, but classic examples that may require surgical interventions include Stevens-Johnson syndrome, ocular cicatricial pemphigoid, and SS. Corneal hypoesthesia or anesthesia also puts the cornea at risk as does the inability to heal in conditions such as post-corneal surgery, radiation keratopathy and recurrent or recalcitrant neurotrophic ulcers.[139]

Systemic treatments

Secretagogues

The muscarinic agonist pilocarpine (Salagen®, 5mg) is indicated for the treatment of dry mouth in patients with SS. Use of this oral formulation is limited due to its adverse effect profile and its q.i.d. dosing. Many patients experience significant adverse effects such as excessive sweating (hyperhidrosis, in over 40% of patients), flushing, chills, nausea, and rhinitis especially at the maximum dose. For this reason it is advisable to start with one daily dose for one to two weeks, then increase to b.i.d. and so on, to allow the patient to become accustomed to the medication. Many patients are unable to reach the full dose, but may be helped by smaller amounts of the drug.

Immunosuppressants

Some immunosuppressive therapy improves symptoms in patients with SS; however, no agents are currently approved for use in this condition. Rituximab has shown some promise by improving salivary flow rate, symptoms, some ocular signs, as well as extraglandular manifestations and some laboratory parameters.[140]

CONCLUSIONS

By defining a more intuitive approach to clinical assessment (episodic, chronic, recalcitrant), the authors hope to help practitioners in the effective assessment and management of the many patients who present to clinical practice with varying levels of symptoms and signs of DED. Beginning with a screening process that involves a series of key questions and an understanding of the predisposing factors that contribute to DED, doctors can more readily differentiate DED from the many conditions that mimic the symptoms. A full DED workup is recommended after screening to confirm the diagnosis, as well as to identify any co-morbidities. Armed with this information, the clinician can readily develop a treatment plan tailored to each patient's condition.

A great deal has been learned about the complexity of DED in the last two decades. The awareness of the inflammatory model of DED is growing, as is the understanding of the long-term management of this spectrum of conditions. Contemporary use of anti-inflammatory treatments has dramatically improved our ability to positively affect patient experience of this chronic disease. Current investigations focusing on the inflammatory model will lead us to future treatment options, and the ability to further improve the quality of life of patients with DED.

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SUPPLEMENTARY APPENDIX

ADJUNCT TESTING AND EMERGING TECHNOLOGIES

The tests described in this section represent emerging technologies that the practitioner may find useful for performing certain assessments in select patients. The Supplementary Table summarizes the equipment that is useful in a dry eye disease (DED) clinic, and includes the time required to administer the test and, where available, the sensitivity and specificity of each test.

NASOLACRIMAL ROUTE PATENCY

The Jones test involves the assessment of the patency of the nasolacrimal duct.[141] Briefly, 2-3 fluorescein strips are placed in the eye and the patient is asked to blink several times to allow the fluorescein to enter the nasolacrimal passageway via the punctum. The presence of fluorescein in the ipsilateral nostril indicates that the passageway is functional. This is a good additional test in patients that complain of epiphora (excessive tearing) to rule out if the nasolacrimal route is blocked.

EVALUATION OF TEAR OSMOLARITY

Osmolarity measures the concentration of ions or particles in fluids such as tears.[8, 142, 143] Osmolarity testing should be performed prior to any other test that requires tear and/or lid manipulation, so as not to potentially affect the results of subsequent tests.

All fluids in the body, including tears, have electrical conductivity properties, depending on the ionic content of the tissue. Any change in the concentration or composition of ions, such as in DED, will affect conductivity. The TearLab Osmometer[144] measures tear film osmolarity using electrical impedance in a 50 nL sample obtained from the lower tear meniscus.

The osmolarity value indicates the severity of DED. A value of more than 308 mOsm/L is indicative of DED and asymmetry between the two eyes is expected, especially with increasing severity.[144-146] Measurements less than 308 mOsmol/L indicate no DED.

The unit has two handles, one for each eye. The individually-packaged disposable tips are inserted onto the handle, after which there is a 2-minute time window to take the measurement. The tip is lowered gently onto the lower temporal tear meniscus and the appearance of an indicator light and an auditory prompt indicates that the required amount of tears (50 nL) has been collected. The handle is then docked onto the base and a reading of the osmolarity is given within a few seconds.

The instrument is user friendly with a quick learning curve (2-3 patients). It is advised to leave the instrument on during the week, as older units take 20-25 minutes to initialize. The newer models only require 5 minutes. Calibration of the unit is recommended every time you open a new box of tips (42 tips/box).

Supplementary Figure 1. *TearLab osmometer.*

Supplementary Figure 2. *TearLab osmometer handle and tear sampling from lower temporal tear meniscus.*

LIPID LAYER ASSESSMENT

Specialized instruments are available to view the lipid layer of the tear film specifically, which is becoming increasingly important as evaporative DED becomes a more prominent concern. The Tearscope (Keeler) uses Ganzfeld-type illumination to view the lipid layer while at the slit lamp and provides a subjective assessment of the thickness of the lipids.[147-149] This instrument is no longer commercially available. The LipiView/LipiFlow® system[56] uses interferometry to view the thickness and quantity of the lipid layer. A lipid layer thickness profile is calculated, which provides an indication of the potential for evaporative DED. The instrument comprises two components, LipiView and LipiFlow®, the latter of which is a therapeutic component (see section on treatment).

The lipid layer creates an interference pattern on the ocular surface that can be used to estimate its thickness. The LipiView system uses interferometry to assess the thickness profile of the lipid layer which can be used diagnostically, and to monitor treatment or post-surgical outcomes.

INFLAMMATORY BIOMARKERS

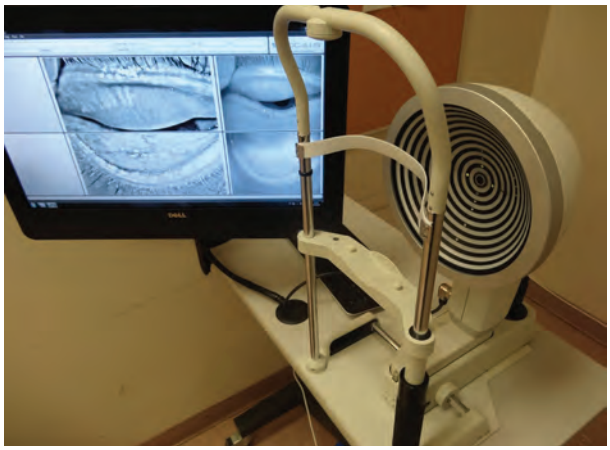
MMP-9 is a non-specific marker of inflammation that is typically found in very low concentrations on the ocular surface in normal individuals and in higher levels in patients with inflammation, such as DED.[150, 151] InflammaDry® measures MMP-9 levels on the ocular surface within 10 minutes of tear collection.[152] An MMP-9 level >40 ng/mL is highly correlated with moderate to severe DED.

MEIBOMIAN GLAND ASSESSMENT

Supplementary Figure 3. *InflammaDry® used to collect tears from the lower conjunctiva for analysis of MMP-9 biomarker.*

The Keratograph (Oculus®) is one of the latest emerging technologies for the assessment of the cornea and tear film. The instrument includes a corneal topographer, an infrared light MG evaluator (Meibo-Scan), and tools for measuring tear meniscus height (TMH), non-invasive TBUT assessment, bulbar conjunctival redness and tear film dynamics.[50] The Meibo-Scan allows the practitioner to assess the linearity and regularity of the MG in both lids. Information regarding how bent or curved the MG are may point towards early signs of MG problems.[153-156]

Supplementary Figure 4. *Keratograph 5M (Oculus).*



Supplementary Table. *Summary of equipment.*

Test	Manufacturer	Time to administer	Sensitivity	Specificity
OSDI	Allergan	< 1 min	80%	79%
McMonnies	N/A	< 1 min	98%	97%
DEQ-5	Indiana University	< 1min	90% (if score >6)	81% (if score >6)
TearLab Osmometer	TearLab	<2 min		
Schirmer	Several available	5 min	85%	83%
CTT/PRTT (ZoneQuik)	Menicon	15 sec	86%	83%
Mastrota Paddle	Ocusoft	<1 min	N/A	N/A
MG Evaluator	Tearscience	<1 min	N/A	N/A
Ophthalmic dyes	Several available	<2 min	N/A	N/A
Yellow Barrier filter	Most GP CL labs	<1 min	N/A	N/A
InflammaDry	Labtician	10 min	85%	94%
Keratograph	Oculus	5-10 min depending on test performed	N/A	N/A
LipiView System	Tearscience	LipiView: <5 min	N/A	N/A

Effective Date: June 2014

7.12 Patients With Amblyopia

Description

Amblyopia (lazy eye) is characterized by reduced best-corrected visual acuity in one or both eyes, without disease or structural abnormality of the eye or visual pathways. It is caused by an interruption of visual sensory stimulation (due to strabismus, uncorrected refractive error or visual deprivation) occurring early in life during the visual-sensitive period. Children and adults with amblyopia commonly experience reduced vision and eye co-ordination that may impact academic, recreational and occupational accomplishments. Optometrists provide diagnosis and treatment of amblyopia, its causes and associated functional visual deficits.

Clinical Guideline

Comprehensive care for amblyopia addresses associated functional visual deficiencies, in addition to the primary visual acuity, refractive and binocular deficits:

- increased sensitivity to contour interaction effects
- abnormal spatial distortions and uncertainty
- unsteady and inaccurate monocular fixation
- poor eye tracking
- reduced contrast sensitivity
- inaccurate accommodative response

Such deficiencies affect visual acuity, patient symptoms and the response to treatment. Assessment and management of these deficits may improve the success of amblyopia treatment.

Additional references relevant to this topic are:

1. American Optometric Association – Clinical Practice Guideline – CPG 4 – Care of the Patient with Amblyopia. **(www.aoa.org)**

2. Pediatric Eye Disease Investigator Group publications. **(http://pedig.jaeb.org)**

First Published: June 2014

7.13 Patients With Uveitis

Description

Uveitis is an inflammatory condition of the eye that may be classified anatomically (based on the part of the eye primarily affected) as anterior, intermediate, posterior, or panuveitic, or based on duration as acute when the condition lasts less than two months, chronic when it lasts longer than two months, or as recurrent when repeated episodes are separated by several months of inactivity.

Anterior uveitis, also known as **iridocyclitis** or **iritis**, is inflammation of the iris and ciliary body. As many as 90% of uveitis cases are anterior in location.

Intermediate uveitis, also known as **pars planitis**, is inflammation of the vitreous cavity (vitritis) sometimes with snowbanking, or deposition of inflammatory material on the pars plana.

Posterior uveitis, also known as **chorioditis**, is inflammation of the choroid that may secondarily involve the retina (chorioretinitis).

Panuveitis is inflammation of the entire uveal tract involving both the anterior segment (iris and ciliary body) and the posterior segment (choroid).

These conditions may occur as a single episode, subsiding spontaneously or with proper treatment, or may become chronic or recurrent in nature.

The practice of optometry includes the diagnosis, treatment and, when appropriate, referral of patients with uveitis.

Clinical Guideline

In addition to the normal complement of required clinical information to be obtained for patients, certain supplementary ocular procedures may be useful in some cases, including but not limited to gonioscopy, diagnostic imaging, and intravenous fluorescein angiography.

Coordination of Care

It is always beneficial to send written reports about patients with uveitis to participating members of their health care team and to keep copies of such documentation in the patient record. Patients should be reminded of the importance of continued compliance with their primary healthcare practitioner's recommendations.

Additional references relevant to this topic are:

American Optometric Association Clinical Practice Guidelines:

- Care of the Patient with Anterior Uveitis **(www.aoa.org)**

First Published: June 2014