College of Opticians of Ontario

Jurisprudence Tool Handbook Important Principles Opticians Need to Know

(Current to June 2021)

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Chapter One
Professional Boundaries and Sexual Abuse Prevention

Introduction

The purpose of this module is to assist registrants in understanding the concepts of professional boundaries and their importance. This module will also help registrants develop ways to prevent the crossing of professional boundaries, including those related to sexual abuse, and to recognize how the College addresses them.

Foundational Concepts

In order to understand the nature of professional boundaries and the harm that can result from crossing boundaries, including sexual abuse, it is useful to consider the applicable core concepts. Three foundational concepts are:

1. Trust: a patient's confidence in the registrant;

2. Power: the authority or influence given to the registrant based on the role or position of the registrant; and

3. Consent: a permission given by the patient to the registrant.

Trust

The professional relationship between a registrant and a patient is based on trust. "Trust" means that the patient feels confident that the registrant is serving the patient's best interests and that the patient can rely upon the registrant not to do anything that could harm the patient. Unless the patient feels "safe" with registrant, the patient will not join with the registrant to achieve the best result. Safety is not limited to physical safety. A fear, no matter how misguided, that a registrant may disclose the patient's personal health information means that the patient will not provide the information needed by the registrant. Similarly, a concern that the registrant is judging the patient may result in the patient answering questions incompletely so as to "get out of there".

Power

The registrant-patient relationship involves a power imbalance in favour of the registrant. Here "power" means that the dominant role of the registrant, in contrast to the "asking" role of the patient, gives the registrant the ability to do things to the patient or to influence the patient that other relative strangers do not have. For example, the registrant has the status of a "professional" and has the role of an "expert". The patient comes to the registrant in a position of need. The patient may have a sense that the patient's vision is "defective". The patient comes relying on the expertise and knowledge of the registrant. The patient is in the position where he or she is expected to disclose personal information about themselves. The registrant is not expected to (and indeed, should not) disclose personal information about themselves. The registrant is in the position to touch the face, particularly the eye

area, of the patient, which involves some intimacy and vulnerability. Patients feel under scrutiny as the registrant examines (indeed, stares at) their face and eyes. Some patients may also be concerned about the cost of the interaction.

A major component of the patient visit relates to the "appearance" of the patient, which makes some people feel quite uncomfortable. Many patients are concerned about how their new appearance will be received by others. With the patient's appearance being a component of the visit, it is easy for the discussion or the registrant's comments to cross over into unprofessional territory.

These feelings can be aggravated if the patient is in discomfort or if the patient does not speak the language of the registrant.

This is not to say that the power differential between the registrant and the patient is always exercised by the registrant or experienced by the patient. Some patients will feel quite comfortable and in control of the interactions. However, it is the patients feeling most vulnerable that are at risk of significant harm from boundary crossing or sexual abuse.

Consent

In both our legal and health care system the control of patients over their bodies and their health care is given enormous weight. In part this is done to counterbalance the power of the registrant. In part it reflects the values of our society. The authority of the patient to control their bodies and their health care requires that they provide informed consent before any health practitioner acts. This includes the asking of questions and the touching of a patient. In some cultures, this patient-centric philosophy is much less valued.

For consent to be informed, the patient must understand the nature of the proposed action (e.g., touching their face), the expected benefit of the action, any material risks or possible side effects, including emotional ones, and the alternatives including doing nothing. The patient also needs to understand that he or she can withdraw consent at any time. It is the responsibility of the registrant to obtain consent before acting. While consent can be implied (e.g., responding to a question asked by the registrant), relying on implied consent raises the chances that the patient did not truly give informed consent (e.g., if the patient did not understand how the answer to a particular question would be used).

Principles

As a result of these foundational concepts the following principles apply:

1. The registrant must always act in the patient's best interests.

2. It is the registrant's responsibility to maintain professional boundaries. The patient is not co-responsible.

3. Failing to maintain boundaries can affect the quality of the outcome for the patient.

4. Crossing boundaries can harm patients and can compromise the public's trust in the profession.

5. Patients must be protected from sexual abuse.

Boundaries

During each visit, registrants must be careful to act as a professional health care provider, and not as a friend, to patients. Becoming too personal or too familiar with a patient is confusing to patients and can make them feel uncomfortable. Patients will be uncertain as to whether the professional advice or services are motivated by something else other than the best interests of the patient. It is also easier for a registrant to provide professional services when there is a "professional distance" between them (e.g., telling the patient the truth about the patient's options and limitations).

Maintaining professional boundaries is, however, also about being reasonable in the circumstances. For example, one should be careful about accepting gifts from patients, but there are some circumstances in which it is appropriate to do so (e.g., a small New Year's gift from a patient). In other areas, however, crossing professional boundaries is never appropriate. For example, it is always professional misconduct to engage in any form of sexual behaviour with a patient.

It is always the responsibility of the registrant to maintain appropriate boundaries with patients. For example, even if the patient initiates the boundary crossing (e.g., brings gifts to the registrant, ignores established customs, tries to become the friend of the registrant), it is the registrant's responsibility to ensure that the boundary is not crossed. For example, if the patient brings an inappropriately expensive or personal gift to the registrant, the registrant should kindly decline it, perhaps by referring to the "rules" that the registrant has to follow.

The following are some of the areas where registrants need to be careful to maintain professional boundaries.

Self-Disclosure

When a registrant shares personal details about his or her private life, it can confuse patients. Patients might assume the registrant wants to have more than a professional relationship. Self disclosure often suggests the professional relationship is serving a personal need for the registrant rather than serving the patient's best interests. Self-disclosure can result in the registrant becoming dependent on the patient to serve the registrant's own emotional or relationship needs, which is damaging to the relationship.

Self-Disclosure Scenario

> *Ayesha, a registrant, is providing contact lenses to her patient Tess. Ayesha is having difficulty deciding whether to marry her boyfriend and talks to Tess about this issue a lot during the visit. To help Tess, Ayesha decides to tell Tess details of her own doubts in accepting the proposal from her first husband. Ayesha tells of how those doubts had long-term consequences, gradually ruining her first marriage as both her and her husband had affairs. Tess is offended by Ayesha's behaviour and decides to go elsewhere for glasses only, which is not the best option for Tess given her prescription.*

This is not to say that registrants can never say anything about themselves. Ordinary conversation always results in some self-disclosure (e.g., an interesting holiday one went on). Any personal revelations should be relevant to the context (e.g., a humorous example of where the registrant not wearing lenses created a problem for the registrant in order to reinforce the need for the particular patient to always use lenses when leaving the house). The point is that registrants need to be careful to ensure that self-disclosure is minimized to the extent reasonably possible and is always appropriate.

Giving or Receiving of Gifts

Giving and receiving gifts is potentially dangerous to the professional relationship. A small token of appreciation by the patient purchased while on a holiday, or given at the end of a series of visits may be acceptable. In addition, one must be sensitive to the patient's culture where refusing a gift is considered to be a serious insult. However, anything beyond small gifts can indicate the patient is developing a personal relationship with the registrant. The patient may even expect something in return. Gift giving by a registrant will often confuse a patient. Even small gifts of emotional value, such as a "friendship" card, can confuse the patient even though the financial value is small. While many patients would find a Christmas / holiday season card from a registrant to be a kind gesture and good business sense, some patients might feel obliged to send one in return. So even here, thought should be given to the type of patients in one's practice (e.g., some new Canadians might be unfamiliar with the tradition).

Gift Giving Scenario

David, a registrant, has a patient from a Mediterranean culture with a large family who all need David's services. The patient brings food on every visit. David thanks her but tries not to treat it as an expectation. On one visit David happens to mention his home-made pizza recipe. The patient insists that David bring it over to her house for Thanksgiving. David politely declines, giving the patient a written recipe instead. The patient stops bringing in food, is less friendly during visits and starts missing appointments. David acted appropriately in this scenario. However, the scenario illustrates the confusion that can occur with a patient when the boundaries start to be crossed.

Dual Relationships

A dual relationship is where the patient has an additional connection to the registrant other than just as a patient (e.g., where the patient is a relative of the registrant). Any dual relationship has the potential for the other relationship to interfere with the professional one (e.g., being both the individual's registrant and employer). It is best to avoid dual relationships whenever possible. Where the other relationship predates the professional one (e.g., a relative, a pre-existing friend), referring the patient to another registrant is the preferred option. Where a referral is not possible (e.g., in a small town where there is only one registrant), special safeguards are essential (e.g., discussing the dual relationship with the patient and agreeing with the patient to be formal during visits and never talk about health issues outside of the office).

Dual Relationships Scenario

Donna, a registrant, has Paula as a patient. Paula is a refugee with very little money. Paula works part-time as a house cleaner. Donna decides to hire Paula to clean Donna's house. Donna also recommends Paula to some of Donna's friends who also hire Paula. Paula is extremely grateful. The following year Donna recommends lenses that will significantly exceed Paula's insurance coverage. Paula wonders to herself if Donna is recommending these lenses in order to get back the money paid for cleaning Donna's house. Paula also feels that she cannot say no or else she will lose her job cleaning the houses of Donna's friends. Did the dual relationship contribute to Paula's confusion?

Ignoring Established Customs

Established customs usually exist for a reason. Ignoring a custom confuses the nature of the professional relationship. For example, meetings are usually held during regular business hours at the dispensary. Meeting the client after hours or at another location (e.g., a restaurant) is outside of the usual practice approach. By ignoring this custom the patient might begin thinking the meeting is a social visit. Or, the patient might feel he or she has to pay for the meal. Treating patients as special, or different from other patients, can be easily misinterpreted.

Personal Opinions

Everyone has personal opinions, and registrants are no exception. However, registrants should not use their position to promote their personal opinions (e.g., religion, politics or even lifestyle) on patients. Similarly, strongly held personal reactions (e.g., that a client is unpleasant and obnoxious) should not be shared. Disclosing personal reactions does not help the professional relationship.

Personal Opinions Scenario

Joel, a patient, while discussing world events with William, a registrant, pushes for William's views on immigration. At first William resists, but eventually says he has some concerns about the abuses of the immigration system. William says he has heard, often directly from patients, about how they have lied to the immigration authorities. Joel responds by loudly criticizing the immigration authorities for allowing too many immigrants into the country. Joel is overheard by other patients in the dispensary at the time, including some who are new Canadians. The other patients tell other staff at the dispensary they feel uncomfortable with either William or Joel around.

Becoming Friends

Being a personal friend with a patient is a form of dual relationship. Patients should not be placed in the position where they feel they must become a friend of the registrant in order to receive ongoing care. Registrants bear the sole responsibility to not allow a personal friendship to develop during professional visits. It is difficult for all but the most assertive of patients to communicate that they do not want to be friends.

Caution should even be taken where pre-existing friends use a registrant's services. At a minimum the registrant should keep the conversation entirely professional in the dispensary. In some cases, where the boundaries cannot be maintained or where the registrant finds it difficult to provide the same level of objective advice as would be given to other patients, the registrant should refer the friend to a colleague. For example, billing a friend for professional services can lead to awkwardness or, possibly even, pressure to be misleading to the friend's insurance company.

Touching and Disrobing

Touching can be easily misinterpreted. A patient can view an act of encouragement by a registrant (e.g. a hug) as an invasion of space or even a sexual gesture. Extreme care must be taken in any touching of patients. The nature and purpose of any clinical touching must always be explained first and the patient should always give consent before the touching begins. The most common touching in opticianry is of the face, particularly near the eyes and ears. Touching these areas is inherently intimate and personal. The degree of discomfort of such touching varies with the personality, age, gender and culture of the patient. Such touching should never be a surprise to the patient. While this advice applies to all patients, it is important to keep in mind that some patients have suffered physical abuse, including face slapping, and suddenly bringing a hand to the patient's face could be startling and upsetting. The registrant should ensure that the registrant consents to any touching.

It is never appropriate for a registrant to ask a patient to disrobe below the neck. For patients who wear head or face coverings any disrobing should be discussed sensitively with the patient. The implications of uncovering the head and face vary significantly from patient to patient. The patient should remove the covering; the registrant should not do it.

Children and Youth

Special boundary issues arise where registrants deal with children. The greatest area of risk is where the parent leaves the child alone with the registrant (e.g., to go shopping where the registrant practises in a mall). The registrant then becomes both the health practitioner and the temporary guardian of the child. Misunderstandings can easily arise (e.g., when dealing with a behavioural issue).

Where the patient enters their teenage years, a different issue arises. There is no minimum age of consent in Ontario. Thus, the registrant has to determine whether the patient is capable of making their own health care decisions. The registrant determines this by assessing whether the patient understands the information necessary to make the decision and appreciates the reasonably foreseeable consequences of the decision. If the patient is capable, it is the patient, not their parent, who has the authority to provide informed consent (including whether their parent should be part of the decision making).

For example, it would be prudent for the registrant to obtain consent for touching the face of a young child patient. The registrant could explain the need to touch the face of the child to the parent beforehand and obtain the parent's agreement. Then, each time the registrant is going to bring his or her hands to the face of the child, the registrant should explain in words what the registrant is going to do. If the child reacts negatively to the touching (e.g., pulling away, crying), the registrant should stop and re-explain things in different words before proceeding.

Managing boundaries is important for both registrants and patients.

Sexual Abuse

The *Regulated Health Professions Act* (*RHPA*) is designed to eliminate any form of sexual contact between registrants and patients. Because of the status and influence of registrants there is potential for any sexual contact to cause serious harm to the patient. Even if the patient consents to the sexual contact, it is prohibited for the registrant.

The term "sexual abuse" is intended to convey how seriously the conduct is taken. However, it should not be thought that only deliberatively exploitative conduct is captured by the phrase. In fact, sexual abuse includes conduct that might, on the surface, appear to be genuine and sincere.

The term "sexual abuse" is defined broadly in the *RHPA*. It includes the following:

1. Sexual intercourse or other forms of physical sexual relations between the registrant and the patient;

2. Touching, of a sexual nature, of the patient by the registrant; or

3. Behaviour or remarks of a sexual nature by the registrant towards the patient.

For example, telling a patient a sexual joke is sexual abuse. Hanging a calendar on the wall with sexually suggestive pictures (e.g., women in bikinis, a "fire fighters" calendar) is sexual abuse. Non-clinical comments about a patient's physical appearance (e.g., "guys won't be able to keep their hands off of you with those glasses") is sexual abuse. Dating a client is sexual abuse. Comments about a patient's sexual orientation, gender identity or gender expression is sexual abuse. For example, insisting that a patient who identifies herself as female use the men's washroom because she is "really" a man is sexual abuse.

It is also important to note that, when it comes to sexual abuse, the *RHPA* takes a very broad approach to determining who is a patient. There is no exhaustive definition, and it can depend on the circumstances. The *RHPA* makes it clear, however, that at a minimum, a person will be considered a registrant's "patient" when they have a direct interaction with the registrant, and any one or more of the following factors are also true:

1. The registrant provided the individual with a health care service and charged the individual for that service, either directly or through a third party (for example, an insurance company);
2. The registrant contributed to the individual's health record or file; or
3. The individual consented to a health care service recommended by the registrant.

There is a very narrow exception, but it would almost never be available to opticians as emergency situations / minor service where the referral of the patient to another practitioner is not possible hardly ever arises in the opticianry context.

At the present time, the definition of sexual abuse includes treating one's spouse. The College is discussing making an exception for treating spouses in some circumstances, but until that exception is

enacted, any such treatment is strictly prohibited. A rare exception would be providing first aid to a spouse in the case of an emergency (e.g., dealing with a foreign object in the spouse's eye). Registrants need to transfer the care of their spouse or lover to another registrant. It does not matter if the spousal relationship came first.

Touching, behaviour or remarks of a clinical nature is not sexual abuse. For example, appropriately touching the face of a patient to adjust glasses is acceptable (with informed consent) and is not sexual abuse. Rubbing the person's cheek affectionately would, however, constitute sexual abuse.

While sexual abuse only relates to patients, sexual misconduct towards other persons can constitute disgraceful, dishonourable and unprofessional conduct. For example, flirting with the parent of a young patient would generally be unprofessional. So would sexual harassment of a colleague or employee.

It is always the responsibility of the registrant to prevent sexual abuse from occurring. If a patient begins to tell a sexual joke, the registrant must stop it. If the patient makes comments about the appearance or romantic life of the registrant, the registrant must stop it. If the patient asks for a date, the registrant must say no (and explain why it would be inappropriate). If the patient initiates sexual touching (e.g., a kiss), the registrant must stop it.

Sexual Abuse Scenario No. 1

> *Natasha, a registrant, tells a colleague about her romantic weekend with her husband at Niagara-on-the-Lake for their anniversary. Natasha makes a joke about how wine has the opposite effect on the libido of men and women. Gwen, a patient, is sitting in a waiting area and overhears. When being treated by Natasha, Gwen mentions that she overheard the remark and is curious as to what Natasha meant by this, as in her experience, wine helps the libido of both partners. Has Natasha engaged in sexual abuse?*
>
> *Natasha clearly has crossed boundaries by making the comment in a place where a patient could overhear it. However, the initial comment was not directed towards Gwen and was not meant to be heard by her. It would certainly be sexual abuse for Natasha to continue the discussion with Gwen. Natasha should apologize for making the comment in a place where Gwen could hear it and state that Natasha needs to focus on Gwen's treatment.*

Because sexual abuse is such an important issue, the College takes it very seriously. The College has a Zero Tolerance policy towards sexual abuse. This means that all complaints or reports are taken seriously, investigated thoroughly and acted upon responsibly. Where the Discipline Committee finds that sexual abuse of a patient has been proved, comprehensive orders are made. While the order made varies with the type of sexual abuse that occurred, where the sexual abuse involved frank sexual acts with patients, the order must include revocation for a minimum period of five years. All findings of sexual abuse are posted, permanently, on the College's public, website register.

Each College must take steps to prevent sexual abuse from occurring. For example, the Patient Relations Committee of the College has developed a sexual abuse prevention plan that will educate registrants,

employers of registrants, and the public, about the nature of sexual abuse, the harm that it causes, the expectations on registrants and how sexual abuse can be avoided.

As discussed in more detail below, registrants are required to make a report where the registrant has reasonable grounds to believe another health care provider has engaged in sexual abuse. The report is made to the Registrar of any health College where the other health provider is a registrant. For example, if a patient tells a registrant her physiotherapist fondled her, the registrant must make a written report to the Registrar of the College of Physiotherapists of Ontario.

There are also a number of special provisions dealing with the handling of sexual abuse matters in the complaints and discipline process. Such complaints are always taken seriously. They are investigated fully. They are not resolved through an alternate dispute resolution process. A referral to discipline is likely where a substantiated complaint of sexual touching of a patient is made. At the discipline hearing the identity of the patient is protected (e.g., if the patient requests, the Discipline Committee will ban publication of the identity of the patient).

The patient may even be given a role at the discipline hearing (e.g., to make a statement on the impact of the sexual abuse on the patient if a finding is made). Where the sexual abuse involved sexual intercourse or the sexual touching of a patient's genitals, anus, breasts or buttocks, and a finding is made, there is a mandatory minimum penalty. Certain offences findings, primarily of a sexual nature, or findings of sexual abuse by other regulators will also result in the mandatory minimum penalty. The registrant's registration will be revoked for a period of at least five years. In all cases where a finding of sexual abuse has been made, the registrant will be reprimanded. If a finding of sexual abuse has been made, the registrant can be ordered to pay for the costs of any counselling and therapy or other support of the patient.

Where an allegation of sexual abuse is made the College is also responsible to pay for at least some of the costs of any counselling or therapy or other support needed by the patient. The Patient Relations Committee administers the funding program. The registrant who was found to have abused the patient can be required to reimburse the College for the funding.

Mandatory Reports

Part of being a registrant of a regulated health profession means that one cannot remain silent when another health care provider is harming a patient. A registrant must speak up in those circumstances. The *RHPA* carefully balances the need to protect patients by requiring registrants to make a report against the need to avoid disrupting the health care system with many unnecessary reports. The statute also recognizes that if registrants unnecessarily report on their colleagues, it will harm the supportive atmosphere necessary for interprofessional collaboration. This section of the handbook describes the mandatory reporting provisions of the *RHPA* that are relevant to sexual abuse. Other mandatory reporting provisions (e.g., for incompetence or incapacity, under the *Child and Family Services Act*) will not be dealt with.

Both the *RHPA* and case law provide immunity to registrants who make a mandatory report in good faith. In addition, other protection is often available. For example, any registrant who retaliates against a mandatory report could face discipline by the College.

The mandatory reporting requirements also create an exception to the registrant's usual duty of confidentiality. In addition, the *Personal Health Information Protection Act* permits a report to the College be made as an exception to the privacy duties under that statute.

Sexual Abuse Reports

A registrant must report sexual abuse by another health care provider. The duty arises if the registrant, in the course of practising the profession or while operating a health facility (which probably includes a dispensary), obtains reasonable grounds to believe the sexual abuse occurred. The reasonable grounds could arise even if the registrant did not personally observe the sexual abuse. For example, if a patient tells the registrant details of the abuse, that would likely constitute reasonable grounds. A registrant does not have to investigate the events further to make a report. Nor does the registrant have to actually believe that the information is true (e.g., the registrant might know the alleged abuser and cannot believe that he or she would do such a thing). If the information constitutes reasonable grounds, the report must be made. Reasonable grounds means information that would cause a reasonable person who does not know the individual involved to conclude that it is more likely than not that the information is correct.

The report must be made in writing to the Registrar of the College with whom the alleged sexual abuser is registered. The report has to contain the reporting registrant's name and the grounds of the report. ***However, the report cannot contain the patient's name unless the patient agrees in writing that his or her name can be included.*** This limitation is intended to protect the privacy of patients who may be in a vulnerable position. The report must be made within 30 days of receiving the information. If it appears that patients are continuing to be harmed and there is an urgent need for intervention, the report must be made right away.

Sexual Abuse Mandatory Report Scenario

Regina, a registrant, is told by Claire, a patient, that Claire had an affair with her family doctor. Regina asks Claire if her family doctor was treating her while the affair was ongoing. Claire says yes. Regina tells Claire that she is required by law to report this information to the Registrar of the College of Physicians and Surgeons of Ontario (CPSO). Regina explains that the CPSO will want to investigate the report. It will be very difficult for the CPSO to investigate the report if Claire's name and contact information is not included in the report. The CPSO will likely want to interview Claire about the affair. The investigation could lead to a discipline hearing. However, Regina cannot include Claire's name and contact information unless Claire is prepared to sign a written consent form permitting Regina to do so. Regina says that they can together call the CPSO right now, on an anonymous basis, to see what the process would be like. Claire agrees to the telephone call. After the call is completed, Claire says that she will not give her consent to include her name and contact information. Regina then provides the report in writing without identifying Claire.

Offenses: Self-Reporting

Registrants have to report themselves when they have been charged with or found guilty of an offence. All offences have to be reported. Thus, criminal offences, offences under federal drug or other legislation

and provincial offences (e.g., occupational health and safety matters) need to be reported. Only courts can make offence findings. Thus, any charges or findings by a body that is not a court (often called "tribunals") are not reportable under this provision. All court charges and findings are reportable regardless of whether or not they resulted in a conviction (i.e., a finding of guilt that leads to an absolute or conditional discharge is not a conviction). Thus sexual offence charges or findings made against a registrant have to be reported to the Registrar of the College.

Registrants are also required to report any bail conditions or other restrictions imposed on or agreed to by them. For example, if the terms of release for the charge require the registrant to only see patients under supervision, that must be reported.

Reports are to be made to the Registrar of the College as soon as possible after the finding and should contain the following information:

1. The name of the registrant filing the report;
2. The nature of, and a description of the offence;
3. The date the registrant was found guilty of the offence;
4. The name and location of the court that found the registrant guilty of the offence; and
5. The status of any appeal initiated respecting the finding of guilt.

The report will be reviewed by the College and may result in an investigation. If there is an appeal of the finding, an updated report must be made.

Registrants must also advise the Registrar if they are registered with a regulatory body for a profession. This applies to both other professions in Ontario (e.g., massage therapy) or in another jurisdiction (e.g., registration as an optician in another province or another country). In addition, if the registrant is found to be incompetent or to have engaged in professional misconduct, the registrant must report the full details to the Registrar as soon as possible. Any changes to the findings (e.g., on appeal) must also be reported as soon as possible.

Sample Test Question

Is a mandatory report required where a registrant overhears another registrant tell two male patients a sexually explicit joke that causes the patients to laugh loudly?

a. *No, dirty jokes are not sexual abuse.*

b. *Yes, this is sexual harassment. The report should be made to the Human Rights Tribunal.*

c. *No, the patients liked the joke and were not offended by it.*

d. *Yes, this constitutes sexual abuse.*

The best answer is **d**. Sexual abuse includes comments of a sexual nature to a patient. Reporting sexual abuse is mandatory. While it is unlikely that punitive action will be taken by the College (perhaps the registrant will be asked to complete a sensitivity course), it is still important that registrants learn that such conduct can be harmful to some patients. One never knows what experiences patients have had in their past that might make even a dirty joke harmful.

Answer a is incorrect because dirty jokes are sexual abuse as that term is defined in the RHPA.

Answer b is not the best answer because there are no mandatory reporting requirements under the Human Rights Code. Also, the RHPA uses the term sexual abuse rather than sexual harassment and gives that term a unique meaning.

Answer c is not the best answer because whether the patient was a willing participant or not is irrelevant. The comment still should not have been made. Also, one never knows what experiences patients have had in their past that might make even a dirty joke harmful. In addition, sexualizing the practice of the profession is inherently confusing to patients who assume that there is not a sexual aspect to their relationship with registrants.

Tips for Preventing Sexual Abuse Concerns

All registrants should consider ways of preventing sexual abuse (or even the perception of sexual abuse) from arising. Experience indicates most sexual abuse is not done by predators. Rather, in most cases the registrant and the patient develop romantic feelings for each other, and the registrant fails to respond appropriately.

Where any romantic feelings develop, the registrant has two choices:

1. Put a stop to them immediately, or
2. Transfer the care of the patient to another registrant immediately.

Other suggestions for preventing even the perception of sexual abuse include the following:

3. Do not engage in any form of sexual behaviour or comments around a patient.
4. Intervene when others, such as colleagues and other patients, initiate sexual behaviour or comments.
5. Do not display sexually suggestive or offensive pictures or materials. Monitor the advertising posters, calendars and magazines used in the dispensary.
6. If a patient initiates sexual behaviour, respectfully but firmly discourage it.
7. Do not date patients.
8. Monitor warning signs. For example, avoid the temptation to afford special treatment to patients one likes, such as engaging in excessive telephone conversations or scheduling visits outside of dispensary hours. Be cautious about connecting with patients on social media.
9. Unless there is a very good reason for doing so, avoid meetings outside of the dispensary.
10. Avoid self-disclosure.

11. Avoid comments that might be misinterpreted ("Those glasses are sexy on you").
12. Similarly, avoid comments about a patient's appearance, clothing or body unless clinically necessary.
13. Do not touch a patient except when necessary for dispensing purposes. If one needs to touch a patient, first explain the nature of the touching, the reason for the touching and be very clinical in one's approach. For example, be sure there is fully informed consent before inserting a contact lens in the eye of a patient.
14. Use informed consent principles before moving into close physical proximity to the face of the patient.
15. Be sensitive when offering physical assistance to patients who may not be mobile. Ask both whether and how best to help them before doing so.
16. Avoid hugging and kissing patients. While there may be rare exceptions (e.g., hugging a long-time, elderly patient who has just lost a close family member), the risk of misinterpretation is high.
17. Be aware and mindful of cultural, religious, age, gender and other areas of differences. If in doubt ask if one's proposed action is acceptable to the patient.
18. If there is a separate fitting room, consider having a third person in the room when with the patient.
19. Where feasible, have an open concept to the dispensary with glass doors and walls so that everyone is visible at all times.
20. Where possible, try to have third parties in the dispensary, particularly when dealing with a vulnerable patient or where a misunderstanding is more likely (e.g., when dealing with a teenager).
21. Do not comment on a patient's romantic life.
22. Ensure any incidents or misunderstandings are fully and immediately documented.

Dating former patients is a sensitive issue. It can still be unprofessional where the registrant still has power over the patient. There should be an appropriate "cooling off" period. In fact, the Act now requires that a one-year cooling off period between the termination of the professional relationship and when a sexual relationship can begin. Otherwise it will still be sexual abuse.
The length of the cooling off period beyond one year will depend on the circumstances (e.g., how long the person was a patient; how intimate the professional relationship was).

Sexual Abuse Scenario No. 2

James, a registrant, is attracted to his patient Alex. James notices he is looking forward to Alex's visits. James extends the visits a few minutes in order to chat informally with Alex. James thinks Alex might be interested as well by the way that he makes eye contact. James notices he is touching Alex on the back and the arm more often. James decides to ask Alex to join him for a coffee after his next visit to discuss whether Alex is interested in him. If Alex is interested, James will transfer Alex's care to a colleague. If Alex is not interested, then James will make the relationship purely professional. James decides to ask a colleague, Navneet, for advice.

Navneet correctly tells James he has already engaged in sexual abuse by letting the attraction develop while continuing to treat Alex. Navneet also says that it is important for James to transfer the care of Alexl right away and certainly before they get together for coffee.

Sample Test Question

Which of the following is sexual abuse:

a. *Commenting that the patient's pupil distance is somewhat narrow.*
b. *Using glamour shots of scantily dressed Hollywood stars as your interior design theme in order to attract younger patients.*
c. *Making repeated passes at the clinic's receptionist.*
d. *Dating a former patient after one-year has passed.*

The best answer is **b**. These pictures sexualize the atmosphere at the dispensary which is inappropriate in a health care setting.

Answer a is not the best answer because the comment about the patient's body is clinically relevant and will affect the options for glasses for the patient.

Answer c is not the best answer because the sexual abuse rules only apply to patients. Sexual harassment of an employee may be both unprofessional under another definition of professional misconduct and a breach of the Human Rights Code, but it is not sexual abuse (unless the receptionist was also a patient).

Answer d is not the best answer because the person is not a patient at the time of dating. However, consideration should still be given to whether a cooling off period of more than one year is appropriate.

Sexual Harassment

While the *RHPA* emphasizes the need to prevent and address the sexual abuse of patients, registrants should also be aware of their obligations to prevent and address sexual harassment in the workplace. Engaging in sexual harassment in the dispensary is unprofessional. It constitutes professional misconduct and opticians have been disciplined for doing so, facing significant disciplinary penalties. Not only is the conduct inherently unprofessional, it also often involves an abuse of power and it inappropriately sexualizes the health care setting. Patient care is easily affected if the trust and respect of the health care team is compromised.

However, sexual harassment at the workplace has many other implications, beyond it being unprofessional. Such conduct breaches the Ontario *Human Rights Code*. The *Code* defines sexual harassment as "engaging in a course of vexatious comment or conduct that is known or ought to be

known to be unwelcome." One incident can sometimes be enough to meet this definition. Examples of sexual harassment include:

- Sexual advances or repeatedly requesting a date.
- A poisoned work environment created by discussing one's sexual activities or teasing others with sexual language.
- Comments and actions that demean a person because of their gender (e.g., expressing views about "women's work").
- Any form of sexual touching such as unwanted hugs or patting or rubbing the body of a colleague.

More recently, sexual harassment has been incorporated into occupational health and safety legislation as a safety issue related to workplace harassment and violence. The definition of sexual harassment in this context is almost identical to that in the *Human Rights Code*: "engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome."

Occupational health and safety legislation makes explicit what has already long been implicit in human rights law, namely the duty of the employer to make every reasonable effort to protect workers from harassment, including sexual harassment. At a minimum, this would involve the development of policies for the organization and the education of staff about the nature of sexual harassment and the need to avoid it. Similarly, occupational health and safety legislation makes explicit the employer's obligation to investigate and address appropriately any complaints of sexual harassment. Such complaints have to be taken seriously and be investigated thoroughly. Where the complaint is substantiated, appropriate discipline measures should be taken as well as measures taken to prevent a re-occurrence of the conduct. Employers also need to take steps to ensure that there is no retaliation against the person making a complaint.

Sexual harassment would often also involve a breach of contract or a civil wrong (called a tort) that could result in a civil court proceeding (e.g., a small claims court action) for damages against both the perpetrator and the employer. In addition, some forms of sexual harassment could constitute a criminal offence (e.g., sexual assault). Thus, opticians have good reasons, relating to their legal duties, workplace morale and the duty to achieve high quality patient care, to ensure that there is no sexual harassment in the dispensary.

Conclusion

Professional boundaries are established to protect both registrants and patients from inappropriate behaviour. A professional boundary demarks the point where the professional relationship has crossed over to another sort of relationship. Sexual abuse is a particularly serious example of a boundary crossing.

Registrants need to understand what kinds of conduct amount to sexual abuse, the harm that can flow from such behaviour, the need to participate in the province-wide effort to eliminate sexual abuse and take reasonable measures to avoid even the perception of sexual abuse. A registrant found to have engaged in sexual abuse will face serious consequences including, in some cases, revocation of his or her registration for at least five years.

Chapter Two:
Record Keeping, Confidentiality and Privacy

The purpose of this module is to assist registrants in understanding the concepts of record keeping, privacy and confidentiality and their importance. This module will also help registrants develop practical skills for making, maintaining, using and disclosing patient records.

Foundational Concepts

In order to understand the expectations of registrants for record keeping, privacy and confidentiality, it is useful to begin with the following basic principles.

1. Personal health information belongs to the patient. It is theirs to provide to their health professionals. Once provided, the information is (with a few exceptions) theirs to control.
2. The reason a patient reveals their personal health information to a registrant is so that the registrant can provide the best possible services to the patient.
3. The reason a registrant collects personal health information from a patient is so that the registrant can provide the best possible services to the patient.
4. It is necessary for registrants to record all relevant personal health information about their patients. Such a record,
    a. enables registrants to accurately recall and use the information for healthcare services now or in the future,
    b. enables others who may be treating the patient to use the information if the registrant is not available,
    c. enables registrants to explain their actions if concerns are raised in the future (e.g., by the patient, the College or a payer), and
    d. can occasionally be used for other valid purposes (e.g., research).
5. There are a few secondary uses of personal health information. For example, the College uses a registrant's patient records for quality assurance purposes to enhance the care provided to all patients of the registrant. Sometimes the information is used by society for compelling reasons that outweigh the usual rights of the patient (e.g., to protect a child in need of protection; to help prove a criminal offence like fraud).

These foundational concepts have numerous significant implications. Because the information belongs to the patient and is to be used for the patient's benefit, the registrant must obtain informed consent to collect, use and disclose the information. The registrant has to carefully safeguard the information. Patients have the right to look at and, where appropriate, correct the information held by the registrant.

This module describes how the above basic principles are applied in actual practice.

Record Keeping

One important aspect of the standards of practice of the profession is record-keeping. Keeping records is essential for providing good patient care; even registrants with excellent memories cannot recall all of the details of their patients' health status, measurements and treatment. Records permit the monitoring of changes in patients. Records assist other practitioners who may see the patient afterwards. Records also enable a registrant to explain what they did for patients if any questions arise. Records help registrants defend themselves if a patient recalls things differently than the registrant. Failure to make and keep adequate records can be a failure to maintain minimum professional standards and is professional misconduct.

The College has a Standard of Practice on Record Keeping (Standard 5) and accompanying Guidelines that deal with matters such as:

1. The information that must be recorded;
2. The form in which records can be kept (e.g., written, computerized);
3. How long the information must be kept;
4. Maintaining or transferring records upon leaving a practice or retiring;
5. Confidentiality and privacy issues; and
6. Patient access to records.

Record keeping expectations apply to various types of records including:

1. Patient files;
2. Billing records; and
3. Patient consent (e.g., for treatment, billing and release of patient information).

Daily appointment schedules and equipment and supply records should also be kept to support the services provided by registrants.

The Information that Must be Recorded

The patient file is intended to record what was done and what was considered by the registrant. It acts as a communication aid to ensure that there is continuity of care for the patient. Proper records also improve patient safety.

The College's Standard 5 on Record Keeping states that an optician must retain complete and accurate patient records that meets the following content criteria:

A patient record must clearly and legibly include the following information appropriate to the appliance that you are dispensing:

1. The patient's contact information.
2. A patient history, including information about the patient's general and optical health, occupation, and relevant hobbies or other regular activities.
3. Complete details of a patient's prescription, including a copy of the original prescription in a form that is unaltered from the manner in which it is received by the optician (e.g. photocopy or electronic scan), the name of the prescriber, and the date of examination.
4. All details of the eyewear dispensed.
5. All contact lenses dispensed including any trial contact lenses.
6. The identity of the optician who fit, verified, and delivered the optical appliance.
7. The ongoing management plan for the patient, including the program or schedule for follow up.
8. If a patient fails to attend or respond to follow up notifications, a notation to this effect.
9. If an optician discontinues services or refuses to perform a service for an existing patient for any reason, a notation to this effect including the reason.
10. If eyeglasses were duplicated from those currently worn by the patient, a notation to this effect.
11. A notation of any service provided to an existing patient (e.g. measurement, fitting or adjustment)
12. If a patient's services are covered by a third party payor, a notation to this effect as well as a copy of any relevant third-party payor documentation.

1. Standard 5 also requires opticians to keep clear and legible financial records pertaining to each service provided to a patient, and any optical appliance that is dispensed, including:The optician's fees for services, product receipts, and any commercial laboratory work orders and/or invoices charged to the patient.

The patient's identifying information should be on each document in the record (whether paper or electronic) so that a particular document may be returned to the record if separated.

The record should include all relevant subjective and objective information gathered regarding the patient. This includes all relevant information provided by the patient (or their authorized representative, or other health care professionals involved in the patient's care) to the optician regardless of the medium or format in which the information was provided (e.g., communicated in person, on paper, email, fax, telephone, etc.). The record also includes any findings from assessments or other observations made even if they were not part of the formal assessment (e.g., if the patient was not able to read the invoice).

The results of any testing done by the registrant should be recorded. If a patient discloses test results from another health professional, it should be noted in the record. However, registrants do not have to ask for copies of reports if they are not needed.

The management plan should be recorded. Then the actual eyewear and services provided should be noted. The record should also include any follow up visits or calls, any changes in the patient's condition,

or any reassessments of the patient or any modifications of the appliance. It should be clear to any practitioner reading the record what happened.

Information from third party payors (e.g. insurance providers) must be kept and recorded, as well as details about fees that are charges for products or services, invoices and laboratory work orders.

If the patient was referred to the optician, the person who made the referral and the reason for the referral should be in the record.

Any consent that is obtained should be included in the record. This includes consent to treatment, consent relating to the collection, use and disclosure of the patient's personal health information and any agreement as to billing.

The Form in Which Records Can be Kept

Records must be legible. Failure to maintain a legible record would defeat the purpose of maintaining a complete and accurate record.

Records can be on paper or on computer, but must include a copy of the patient's original prescription in a form that is unaltered from the manner in which it is received. This means that if the prescription is received on paper, the registrant must make and retain a photocopy, electronic scan, or digital photograph of the prescription. It will not be sufficient to transcribe the prescription details into the file. Computerized records should be printable and viewable and should have an audit trail of changes made. These requirements are discussed further in the discussion of the *Personal Health Information Protection Act (PHIPA)* below.

It should be clear who made each entry into the health record and when that entry was made. Any change or amendment to the record should be indicated, the date of which the change was made should be noted, and who made the change should be recorded. Importantly, any changes to the record should still permit the reader to read the original entry.

Registrants cannot falsify records; this means that if an error is made in a previous entry it cannot be removed (e.g., 'whited-out', or deleted). The record should be maintained with correction to the error (usually a simple line through the error with the date and initial of the person correcting the error).

The record should be in English or French. The information can be recorded in other languages so long as all the information is also recorded in English or French. The generally accepted languages in the health care system in Ontario are English or French. This permits other health care providers on the patient's health care team (e.g., other opticians, other health care providers) to understand the record.

How Long the Information Must be Maintained

Relevant personal health information should not only be recorded, it must also be kept until it is unlikely to be needed again. The College has established guidance to the profession to ensure that the

information is not only available for future services to the patient, but is also available for other purposes including responding to concerns or complaints about the registrant's services and conduct.

The College's Standard 5 on Record Keeping states that a registrant must retain records as follows:

Retaining Records:

1. An optician shall ensure that all patient records are retained for seven years from the date of the last entry, or for a patient who is under the age of 18, for seven years after the patient's eighteenth birthday.

2. An optician shall maintain their records in a manner that ensures that a patient or authorized College investigator, assessor or representative has access to the records.

3. An optician who is a health information custodian shall ensure that files are not abandoned when the optician retires, sells their practice, or closes their practice for an extended period. The optician shall ensure that files are transferred securely and in accordance with applicable privacy legislation, or in the case of an extended closure, shall take reasonable steps to ensure that patients can access their files during the closure.

The registrant (or health information custodian for whom the registrant works) needs to keep the record for seven years from the last interaction with the patient (as all interactions are expected to be recorded). An interaction can involve any contact with the patient, including a phone call or an email.

The rule regarding keeping records for seven years applies to clinical, financial, appointment and attendance records.

The following guidelines published by the College apply when a registrant stores patient records at a third-party storage site:

i. The storage facility should have a privacy policy that is consistent with PHIPA and the College's record keeping requirements.
ii. The optician should obtain written assurance that the facility will safeguard the information and only disclose it if the optician specifically requests this.
iii. If the facility will destroy the records at a later date, the optician should contract with the facility to retain the records for the seven years and destroy the records in a secure manner.
iv. The optician should keep the account with the storage facility current at all times to ensure that records are not destroyed prematurely.
v. The optician should keep records of what files are retained at the third-party site.
vi. If the optician is in active practice, the optician's privacy policy should state that the optician uses a third-party storage site.

Maintaining or Transferring Records Upon Leaving a Practice or Retiring

The entire original record should be kept by the registrant (or the health information custodian for whom the registrant works) and only copies should be supplied to others.

Even when a registrant retires or leaves the practice (i.e., resigns as a registrant of the College) the original record should be kept for the seven-year retention period, unless the record has been transferred to another practitioner who will maintain the record. The patient must be notified of the transfer. In those circumstances, the original record (and not just a copy) can be transferred to the new practitioner.

However, if just the patient has been referred to another health care professional and the patient record has not been transferred, then the retention period of the entire original record (i.e., seven years from last contact) is still mandatory.

An exception to keeping the original record is where there is some legal duty to provide the original record to someone (i.e., in a police investigation, Coroner's or College investigation, or where there is a summons). If this circumstance occurs, the registrant should keep a legible copy of the record for themselves.

Special rules apply when opticians work with optometrists. Optometrists are expected to keep their own records when they leave a practice. Thus, even if the optician owns the practice location, separate files should be kept so that the optometrist can take his or her own files when he or she leaves. Registrants need to be careful not to pressure or require an optometrist to breach his or her own standards of practice even when the optician owns the practice location. For example, optometrists are required to retain their records for at least ten years (not seven as for opticians) and to retain access to the records even after they leave the practice location. In addition, opticians have no right to access optometry records for marketing purposes even if they own the practice location.

When the time period for keeping the record has expired, the destruction of the records should be done in a secure manner that prevents anyone from obtaining the information (i.e., shredding, complete electronic destruction). If a registrant destroys any records, a good practice would be to keep a list of the names of the files that were destroyed and the date they were destroyed.

When transferring from paper records to an electronic record keeping system, the original may be destroyed after it has been scanned and stored. The electronic version of the document becomes the original.

Confidentiality and Privacy Issues

Registrants should take reasonable steps to keep records safe and secure. In general, no one outside of the authorized circle of care of health professionals should be able to have access to the records. Privacy protections must be in place to ensure the records cannot be seen, changed or taken by others. Paper

records should be kept under lock and key. Computer records need to be password protected on computers that have firewall and virus protections and must be backed up regularly. Particular privacy issues are discussed in more detail below.

Patient Access to Records

Generally, a patient has the right to review and receive a copy of all clinical records kept by a registrant unless access would significantly jeopardize the health or safety of a person. Although the registrant may own the health care record and be responsible for it, patients are authorized by the *Personal Health Information Protection Act* to access the record. The information in the record really belongs to the patient. Also, the patient has the right to correct any errors in the health record. If a patient requests any relevant parts of the record, the registrant should provide them with a copy and not the original.

Record Keeping Scenario

Pavan been practising for 45 years and has built up a busy and successful practice. He decides he is ready for retirement but wonders what he is supposed to do with his patient records. Does he have to retain them himself? Ordinarily he would have to retain patient records for seven years from the last interaction with the patient. But in this case Pavan may be selling his practice to another optician who will take over the business and patients. The buying optician will likely agree to keep the records for the seven-year period. If this is the case, Pavan does not have to retain the records himself, but needs to notify the patients of the transfer of their patient records. This can be done through a combination of telling patients on their next visit, sending out letters and placing a notice in the local newspaper.

Sample Exam Question

Which one of the following does not need to be recorded in the patient's record?

a. The patient's birth date.
b. The person who recommended the patient to you.
c. The patient's health concerns.
d. The management plan for the patient.

The best answer is **b**. Only if the patient was referred by another health care provider must there be a record of who recommended the patient. If another patient referred the person or the person found out about your office through advertising, that does not have to be recorded (although in some cases it would be helpful to record this information).

Answer a is not the best answer because registrants need to record the patient's birth date. It is relevant to many management decisions.

Answer c is not the best answer because registrants need to record the patient's health concerns (sometimes called history). It is relevant to many management decisions.

Answer d is not the best answer because registrants need to record the management plan for the patient. It is relevant to following up on future visits and for justifying one's actions should questions be raised later.

Confidentiality and Privacy

Personal Health Information

The concepts of privacy and confidentiality are similar, but not identical. Confidentiality is a professional obligation owed by registrants to their patients. The regulations make the following to be professional misconduct:

> 10. Giving information about a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required or allowed by law.

Confidentiality obligations are enforced by the College and, to lesser extent, the courts.

Privacy on the other hand, goes much further. Privacy provisions begin with the concept that all personal health information belongs to the patient and that the registrant holds it in trust for the benefit of the patient. Registrants have a duty to protect the privacy of patients' personal health information. Privacy principles are set out in the *Personal Health Information Protection Act* (*PHIPA*). *PHIPA* looks at the collection, use and disclosure by registrants. It also looks at the access given to patients to their own personal health information. Privacy obligations are enforced by the Information and Privacy Commissioner of Ontario. Failing to meet privacy obligations is also likely to be a breach of the College's record keeping standard and may be professional misconduct.

Personal health information refers to almost anything that would be in a registrant's files on a patient. It is defined in *PHIPA* as written or oral identifying information about a person, if the information:

1. Relates to the person's physical or mental health, including the person's family health history;
2. Relates to the providing of health care to the person, including the identification of a person as someone who provided health care to the person;
3. Is a plan of service within the meaning of the *Home Care and Community Services Act,*
    a. *1994* for the person; iv. Relates to the person's payments or eligibility for health care, or eligibility for coverage for health care;
4. Relates to the donation by the individual of any body part or bodily substance of the person or is derived from the testing or examination of any such body part or bodily substance;
5. Is the person's health number; or
6. Identifies a person's substitute decision-maker.

Identifying information about a person is also considered to be personal health information when it is contained in a record of personal health information.

Health Information Custodians

PHIPA places significant obligations on Health Information Custodians (a Custodian). A Custodian is the person or organization responsible for all health records. The Custodian must create, implement and oversee a privacy policy that meets the requirements of *PHIPA*.

A sole practitioner would be the Custodian of any health information and records that the registrant collects. If a registrant works for a health services organization such as a clinic or chain of offices, the organization is usually the Custodian of health records.

Many registrants work for organizations like department stores. Typically the organization is the Custodian. However, even where the registrant is not the Custodian, the registrant has privacy obligations. For example, the registrant needs to follow the privacy policies that protect patients (e.g., security policies and safeguards such as using complex passwords). In addition, the registrant has to work with the Custodian to ensure that the registrant's record keeping obligations are met. College publications and professional standards of practice still apply to the registrant even if the registrant's employer is not regulated by the College. Registrants cannot work for employers who disregard professional standards. For example, the registrant must ensure that all required information is recorded and that the record is retained for the required period of time (i.e., seven years).

Two or more registrants who work together may decide to act as a single organization for the purposes of *PHIPA*. This may be helpful because the registrants can create a single privacy policy. This would allow for consistent health record keeping practices. In this case the registrants will have shared responsibility for complying with *PHIPA*.

Information Officers

PHIPA requires every Custodian to appoint a contact person (often called an Information Officer). An Information Officer is the person who makes sure everyone follows the requirements of *PHIPA*. The Information Officer reviews the organization's privacy practices, provides training, and monitors compliance. The Information Officer is also the contact person for requests for information from the public.

A sole practitioner usually acts as Information Officer himself or herself. An organization may appoint a person within the organization, or may hire a person outside of the organization to be its Information Officer.

PHIPA Scenario

> Three registrants work together in an office. They decide they will act as an organization for privacy purposes. Their organization is the Health Information Custodian. The registrants create a privacy policy together. The registrants decide to appoint the most senior optician to be the Information Officer. The Information Officer creates a

procedure to protect personal information, develops a privacy complaints procedure, and ensures that all registrants comply with the privacy policy.

Protecting Personal Health Information

Custodians must put in place practices to protect personal health information in their custody or control. They must take appropriate measures to protect personal health information from unauthorized access, disclosure, use or tampering. The nature of those safeguards will vary depending on the sensitivity of the information and the circumstances. Personal health information is generally considered highly sensitive.

Those safeguards must include the following components:

1. Physical measures (For example, restricted access area and/or locked filing cabinets)

2. Organizational measures (For example, need-to-know and other employee policies and/ or staff training); and

3. Technological measures (For example, passwords or encryption and/or virus protection or firewalls).

For example, the Information and Privacy Commissioner has made numerous orders and issued bulletins and fact sheets indicating that health practitioners cannot store personal health information on mobile devices unless the devices are encrypted. Simply using password protection to enter the device is insufficient.

Registrants need to systematically review all of the places where they may temporarily or permanently hold personal health information (including laptops, smartphones and other handheld devices) and assess the adequacy of the safeguards. Almost every organization that has not done this before will find that it needs to make changes.

Registrants storing their information in the "cloud" should try to avoid using a cloud company that has servers in the United States as their laws allow extensive government access to the information. In addition, registrants should ensure that the cloud company has a trustee that will hold the information if the company goes bankrupt so that the cloud company's creditors do not then take possession of the information.

If there is a privacy breach, registrants should take the following steps:

1. Take immediate steps to contain the breach. The registrant should try to retrieve the compromised information if it is still outside of the registrant's control. If the information has been stolen, the police may need to be called. The Information and Privacy Commissioner may be able to assist the registrant in doing so.
2. Notify the individuals whose information has been compromised of the breach. This disclosure is now required by *PHIPA*. If the registrant is not the custodian, the registrant must notify the custodian of the privacy breach so that the custodian can notify the patients. This step will often involve making an apology and, sometimes, making amends.Notify the Information and Privacy Commissioner if the information has been or

will be used or disclosed without authority, or if the breach is significant, involves stolen information, or is part of a pattern of similar breaches.

3. Notify the College AND the Information and Privacy Commissioner if certain types of disciplinary actions (e.g., suspensions, terminations, resignations) are taken against a registrant or another registered health practitioner for the unauthorized collection, use, disclosure, retention or disposal of personal health information.
4. Review and revise the registrant's policies and procedures. Assess what went wrong and what steps need to be taken so that this sort of privacy breach (and another other privacy breach) does not recur in the future.

As noted above, registrants also need to securely keep, transfer and dispose of records in accordance with the College's expectations.

A registrant's or organization's privacy policy should explain how health information will be protected.

Collection, Use and Disclosure of Personal Health Information

A registrant or organization must only collect, use, or disclose a person's personal health information if the person consents or if the collection, use or disclosure is otherwise permitted or required by law. A registrant should collect, use or disclose no more information than is reasonably required in the circumstances.

A registrant's or an organization's privacy policy should clearly explain how and when personal health information will be collected, used and disclosed.

Under *PHIPA*, collection, use and disclosure of personal health information is permitted without a patient's consent in limited circumstances. Below are some common situations where the rules about collection, use and disclosure of the personal health information may arise.

Circle of Care

A registrant can share personal health information with other individuals within a patient's "circle of care" for the purposes of providing health care, without the patient's express consent.
A circle of care may include other health professionals who provide care to the same patient (e.g., a physician, an optometrist). A registrant is generally permitted to assume that he or she has a patient's implied consent to disclose personal health information to other health providers in the patient's circle of care.

A registrant who is working in a multidisciplinary setting may, for the purpose of treatment, share personal health information with other health care professionals who are providing care to the same patient because these other health care professionals are within the patient's circle of care.

A registrant who refers a patient to another health professional may consider that health professional to be within the patient's circle of care. The circle of care of a registrant's patient may also include other health care providers in other institutions if it is necessary for providing health care to the individual and it is not reasonably possible for consent to be obtained in a timely manner.

However, many practitioners do not share information with others in the health care team without the patient's explicit consent unless it is an emergency so as to avoid misunderstandings. This is especially important where the information is sensitive (e.g., the patient is worried that their vision limitations may place their job in jeopardy).

An exception to the circle of care rule is if a patient says that he or she does not want the information to be shared. The information must then not be shared unless another provision in *PHIPA* permits it (this direction from a patient is often referred to as placing the information in a "lock box").

Circle of Care Scenario

> *Kelly, an optician, receives a telephone call from an optician in cottage country. A patient has lost their glasses in a boating accident and cannot drive without a replacement pair. The patient is in the hospital and is not accessible. The cottage country optician wonders if Kelly can provide her pupillary distance measurements for the patient and any other relevant information. While Kelly could insist on speaking with the patient to obtain express consent to share this information, she would be entitled to disclose the information without express consent by relying on the circle of care concept.*

Family and Friends

Generally speaking, consent should be obtained before sharing personal health information with members of a person's family.

However, personal health information may be disclosed for the purposes of contacting family members, friends, or other persons who may be potential substitute decision-makers if the patient cannot provide consent (e.g., the patient is incapable).

Disclosure Related to Risk

A registrant may disclose a person's personal health information if the registrant believes on reasonable grounds that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to the person or anyone else.

For example, if a patient has threatened to kill someone, the registrant can warn the person being threatened and call the police. The registrant could share any information about the patient that will help the police to deal with the threat. In some circumstances this principle can apply to patient-harm as well (e.g., where the patient is suicidal).

Perhaps the most common example of where this might happen is where the optician is concerned about the patient's ability to drive safely. While not covered by the same mandatory reporting requirements as an optometrist, a registrant may feel that in some rare circumstances they are in the best position to disclose the risk in order to avoid a serious risk of harm.

Other laws

PHIPA allows disclosure of personal health information that is permitted or required by many other Acts, including the following:

- The *Health Care Consent Act* or *Substitute Decisions Act* for the purposes of determining, assessing or confirming capacity;
- Disclosure to a College acting under the *Regulated Health Professions Act* (e.g., in relation to a peer assessment or a complaint against a registrant); and
- Disclosure to an investigator or inspector who is authorized by a warrant or by any provincial or federal law, for the purposes of complying with the warrant or facilitating the investigation or inspection.

Additionally, there are some circumstances in which there is a mandatory reporting duty to disclose personal health information. For example, where a registrant reports to the College that a colleague is leaving the practice because of the colleague's incompetence, the report will contain some personal health information about affected patients.

Access to Personal Health Information

Every patient has a right to access his or her own personal health information. There are very few exceptions. One important exception is if granting access would likely result in a risk of serious harm to the patient's treatment or recovery, or a risk of serious bodily harm to the patient or another person.

If a person makes a request to access personal health information, the registrant or organization must:

1. Permit the person to see the record and provide a copy at the person's request;
2. Determine after a reasonable search that the record is unavailable, and notify the person of this in writing as well as his or her right to complain to the Information and Privacy Commissioner of Ontario; or
3. Determine that the person does not have a right of access, and notify the person of this as well as his or her right to complain to the Information and Privacy Commissioner of Ontario.

The Information and Privacy Commissioner, a government appointed official administering *PHIPA*, may review the registrant's or organization's refusal to provide a record, and may overrule the decision.

Where some, but not all of the information can be withheld, the registrant should black out (on a copy, not the original) those parts that should be withheld, so that the patient may see the rest of the record.

Sample Exam Question

A patient asks an optician to provide the patient's pupillary distance. How should the optician respond?

a. *Refuse to provide the information because it would put the health and safety of the patient in jeopardy.*

b. *Provide the information because it belongs to the patient.*

c. *Refuse to provide the information because it is the product of the optician's own measurements and was not provided by the patient.*

d. *Provide the information only if the patient promises not to order lenses online.*

The best answer is answer **b**. A patient's right to access his or her health information is broad and would almost certainly cover this request. Answer a is not the best answer because the risk of harm, if there is one, is likely not significant. Answer c is not the best answer because even a registrant's measurement results constitute patient health information covered by the right of patient access. Answer d is not the best answer because the right of patient access does not depend on how the patient plans to use the information.

Correction of Personal Health Information

Patients generally have a right to ask for corrections to their own personal health information. A registrant or organization receiving a written request must respond to it by either granting or refusing the request within 30 days. It is wise to respond to verbal requests as soon as possible as well. If the request cannot be fulfilled within 30 days the person should be advised of this in writing.

Corrections to records must always be made in a way that allows the original record to be seen. The original record should never be destroyed, deleted, or blacked out. If the record cannot be corrected on its face, the correction should be made so that any person accessing the record will see the correction or know where to find the correct information (e.g., by means of a footnote or link in an electronic record). The patient should also be notified of how the correction was made.

At the patient's request, the registrant should notify anyone to whom the registrant has disclosed the incorrect information of the correction. An exception to this is if the correction will not impact the person's health care or otherwise benefit the person.

The registrant or organization may refuse the request if the registrant or organization believes the request is frivolous or vexatious (e.g., it simply repeats a previous request that has already been denied); if the registrant did not create the record and does not have the knowledge, expertise and authority to correct it (e.g., a physician's diagnosis), or if the information consists of a professional opinion made in good faith (e.g., the optician documents a recommendation that a patient is not suitable for contact lenses). In other words, corrections are limited to factual information, not professional opinions.

A registrant who refuses to make a correction must notify the patient in writing, with reasons, and advise the patient that he or she may:

1. Prepare a concise statement of disagreement that sets out the correction that the registrant refused to make;

2. Require the registrant to attach the statement of disagreement to his or her clinical records and disclose the statement of disagreement whenever the registrant discloses related information;
3. Require the registrant to make all reasonable efforts to disclose the statement of disagreement to anyone to whom the registrant has previously disclosed the record; or
4. Rake a complaint about the refusal to the Information and Privacy Commissioner.

Complaints

Every organization must have a system in place to deal with complaints regarding personal health information. Patients should also be aware of their right to complain to the College and/or to the Information and Privacy Commissioner.

PIPEDA

Another privacy law that registrants should know about is the *Personal Information Protection and Electronic Documents Act* (*PIPEDA*). *PIPEDA* is a federal law that looks at the collection, use and disclosure of personal information in relation to commercial activity **outside of** health care.

PIPEDA applies only to commercial activities of registrants, such as the sale of non-health products at registrants' offices (e.g., the sale of non-prescription squash or scuba goggles, safety eyewear, designer sunglasses, readymade magnifiers) and the offering of educational sessions. Unlike *PHIPA*, which governs personal health information, *PIPEDA* governs all types of nonhealth personal information. Examples of personal information include the person's name, date of birth, and home address.

The following ten privacy principles apply to a registrant's commercial activities:

1. Accountability: Someone in an organization (the "privacy officer", sometimes called an "information officer") must be accountable for the collection, use and disclosure of personal information. The privacy officer must develop privacy policies and procedures and ensure that staff receive privacy training.
2. Identifying Purposes: An organization must identify the purposes for which personal information will be used at the time that the information is collected.
3. Consent: Consent is required to collect, use and disclose personal information, except in limited circumstances (e.g., in emergencies or where the law otherwise permits this).
4. Limiting Collection: An organization must only collect the information that is necessary to collect for the identified purposes.
5. Limiting Use, Disclosure and Retention: An organization must only use, disclose and retain personal information that is necessary for the identified purposes and is obtained with consent. It should be retained no longer than necessary.
6. Accuracy: An organization must make reasonable efforts to ensure that any personal information collected is accurate, complete and up-to-date.

7. Safeguards: An organization must protect personal information with appropriate safeguards in order to protect against loss, theft, unauthorized access, disclosure, copying, use, or modification.

8. Openness: An organization must make its privacy policies readily available.

9. Individual Access: Upon request, an individual must be informed of the existence, use and disclosure of his or her personal information, and be given access to it. An individual can request corrections to the information. Access may be prohibited in limited circumstances such as the privacy of other persons, if there is a prohibitive cost to provide it, or for other legal reasons.

10. Challenging Compliance: An organization must have a complaints procedure relating to personal information and must investigate all complaints.

As you can see, *PHIPA* and *PIPEDA* are based on the same principles. *PHIPA* simply provides more details about how to achieve those principles in the health care context.

Conclusion

Patients own their personal health information. Patients reveal this information to registrants so that the registrant can provide the most effective management of their vision possible. Thus registrants have a duty to record the information and then to hold it in trust for the patient. Registrants must safeguard the information and provide access to it when requested by the patient.

Chapter 3:
Communications

Introduction

The purpose of this module is to assist registrants in understanding the various methods of effective communication and their importance. This module will also help registrants develop practical skills for ensuring effective communication and avoiding unhelpful communication.

Foundational Concepts

In order to understand the expectations of effective communication, it is useful to begin with the following basic principles:

1. Effective communication with patients, colleagues and third parties is essential to meeting almost all of one's professional obligations.
2. There are specific challenges in opticians communicating effectively with their patients that must be taken into account. For example, opticians are very familiar with technical information that most of their patients do not understand.
3. There are strategies that opticians can consciously adopt to facilitate effective communication.

Appreciating and applying these principles leads to effective communication skills.

How Effective Communication Skills Advance Good Practice

It is difficult to think of an area of practice that is not enhanced by effective communication. Conversely, it is also hard to imagine an area of practice that would not be compromised by poor communication. Patients who understand their practitioners are more likely to acknowledge their condition, understand their options, modify their behaviour and follow their practitioner's recommendations.[1] Indeed, the second entry-to-practice competency deals with communications.[2] Studies have shown that the quality of communication in the history-taking and treatment discussion portions of the patient visit influences patient outcomes.[3]

Consider the following examples:

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[1] John M. Travaline, et. al, "Patient-Physician Communication: Why and How", Journal of the American Osteopathic Association, 2005: Vol. 105, No. 1 at p. 13.

[2] NACOR, *National Competencies for Canadian Opticians*, 3rd Edition April 2013.

[3] John M. Travaline, et. al, "Patient-Physician Communication: Why and How", Journal of the American Osteopathic Association, 2005: Vol. 105, No. 1 at p. 14.

1. Obtaining informed consent is necessary in order to treat patients. Only through obtaining accurate information about a patient's routines can one advise them on what vision devices would best meet their needs.

2. Boundary encroachments tend to be either physical or verbal. By ensuring that the patient understands the nature and purpose of any touching or physical proximity, one can avoid misinterpretations of one's actions. In addition, by sensitively choosing one's words, one can avoid upsetting or offending a patient, colleague or third party.

3. The vast majority of complaints that the College receives relate in some way to communication issues. Complaints can be avoided by practising clear and appropriate communication. Similarly, one can turn a minor matter into a formal complaint by failing to respond to a patient's concerns or responding in a manner that aggravates the situation.

4. Patient safety is jeopardized by dispensing inappropriate lenses. To determine the appropriateness of a possible lens, the optician has to understand a patient's habits and activities. Most patients do not know what information the optician requires until they have been asked by the optician.

5. Many conflicts of interest can be mitigated by following the DORM principle: **disclosure** of the interest that the optician has in the recommendation; providing **options** to the patient; **reassuring** the patient that choosing any of those options will not affect their relationship with the optician; and, sometimes, **modifying** the recommendation so as to reduce any self-interest on the part of the optician. The DORM principle requires effective communication with the patient.

6. Patients have the right to access their records. Most patients, however, do not know what kind of information is contained in their records, nor do they understand the meaning of the contents of their records. To make the patient's right of access meaningful, the optician must explain both the contents and their meaning to patients.

7. Mandatory reporting requirements can be upsetting to a patient. Most patients assume that all of the information they provide to the optician is confidential and do not realize that there are exceptions. For example, where a patient discloses that they have been sexually abused by another practitioner, the optician must make a mandatory report. The patient's surprise can be reduced if one explains early in the patient-optician relationship that there are some exceptions to the privacy of their information. Where a mandatory report has to be made, discussing this with the patient in advance can reduce the patient's distress. In addition, communicate with the patient as to whether they want their name to be included in the report. This will ensure that one is complying with the provision that the patient's name can only be included in the report if the patient agrees in writing.

8. Apart from safety concerns, effective patient treatment can only be achieved through effective communication. Knowing the patient's lifestyle and work requirements can suggest a particular approach. For example, a patient who spends long hours in front of a computer screen might

need different forms of assistance with their vision than a construction worker. Talking with the patient will help enormously with the effectiveness of treatment.

9. While opticians cannot communicate a diagnosis, they do advise patients of the results of their assessment. For example, explaining why one is not recommending contact lenses to a patient who is inclined to obtain them can only be persuasive if the patient understands what the assessment revealed.

10. Confidentiality is an essential professional duty. Understanding precisely what a patient means when they are asking for some (but perhaps not all) information to be disclosed to a third party requires careful communication. Similarly, it is essential to understand precisely to whom the information should be revealed and by what means of transmittal.

The above are just a few examples of how important effective communication is to every aspect of an optician's practice. There are many other areas where this is important as well.

Communication Scenario

> *Sargon operates an independent dispensary. He has dispensed some lenses in high-end frames to Upeksha. Upeksha returns a week later asking for a refund because she does not like the frames. Sargon says "There are no returns. You bought them. They are yours." Upeksha becomes upset, indicating that she thought she had a cooling off period to try them out. Sargon points to the fine print in the receipt issued to Upeksha indicating that the "glasses cannot be returned once dispensed". Upeksha makes a scene, disturbing other customers in the dispensary. In a loud voice Sargon orders Upeksha to leave his property and to never come back. Upeksha makes a complaint to the College.*

There are many ways in which Sargon's communication with Upeksha could have been improved. This entire situation could probably have been avoided if Sargon had clearly explained his return policy verbally to Upeksha when she was choosing the frames. It would have been helpful if Sargon had also explained the reasons for the policy as well (e.g., that Sargon had already paid for lab costs of making the lenses; that once lenses are made they generally do not fit in other shaped frames; and he does not want to give any of his patients, including Upeksha, used frames). Asking for a response from Upeksha (e.g., "You would not want me to be selling you used frames would you?") would have either confirmed that Upeksha understood the conversation or would have made Sargon aware that further explanation was required.

A note in the fine print of the receipt after the transaction is finalized is too little too late. Upeksha probably did not even notice it. In addition, the note is not clearly written. Upeksha might have thought that "glasses" meant only the lenses, not the frames, and she might not have understood that lenses cannot be readily inserted into another frame. Also, not everyone is familiar with the word "dispensed".

As soon as Upeksha came into the store with a concern, Sargon should have first acknowledged her feelings before addressing the merits of the request. Saying something like: "I see that you are upset" or "I am sorry to hear that you are not pleased with the glasses" would reassure Upeksha that you are

listening to her and that you are concerned about her displeasure. Acknowledging a patient's concerns (so long as it is sincere and is not manipulative) can help transition an emotional conversation into a factual one.

Sargon is obviously concerned about other customers hearing the conversation. Depending on the circumstances[4], it may be appropriate to invite Upeksha to have the conversation in a more private setting. However, that invitation is more likely to be accepted if it is suggested early in the conversation, perhaps right after acknowledging Upeksha's feelings. Issuing the invitation after the conversation has already escalated is not only too late in terms of the other customers, it is more likely to be refused. Again, providing an explanation for the invitation can help Upeksha understand its purpose. For example, Sargon could say: "Let's step into my office where I can get out your file and where I can better respect the privacy of your information."

In the scenario, Sargon's response was abrupt, accusatory and dismissive. That is almost guaranteed to make a patient more upset. Even if Sargon is not prepared to offer any concessions to Upeksha, he should explain this to her in a sensitive manner and provide a reason as to why he is unable to do so. The language chosen should be thoughtful and should address Upeksha's concerns.

While the whole situation is uncomfortable, Sargon should accept that it takes time to have a successful conversation with someone who is upset. If Upeksha is willing to tell her story, Sargon should be willing to listen. He could perhaps ask an open-ended question such as "Tell me what you have been experiencing". In a few cases this can result in the patient becoming even more upset. It is far more common, however, for the patient to work through their feelings if they sense that they are really being listened to. At this point, Sargon should listen and not interrupt with advice, recommendations or solutions. Upeksha needs to tell her story and Sargon needs to listen to see what is really behind Upeksha's request for a refund.

Sargon escalated the conflict by using a loud voice and demanding that Upeksha leave the dispensary. Escalating a conflict is almost always a bad communication strategy. The other party can escalate as well, verbally or even physically (e.g., knocking things over or even assaulting Sargon). In addition, the escalation greatly increased the chance that Upeksha would make a complaint to the College, which ends up giving Sargon a long-term issue to deal with even if the complaint is eventually dismissed (and the complaint might not be dismissed). At a minimum, Sargon now has a complaint history that the College is required, under the *Regulated Health Professions Act*, to consider in all future complaints. Sargon should have de-escalated the situation as described above. Actions as simple as using a soft voice and using the person's name are de-escalating.

Using effective communication techniques would have almost certainly resulted in a better outcome for Sargon.

[4] There may be safety or boundary issues to take into consideration when inviting a patient to go alone into a private room.

Barriers to Effective Communication with Patients

There are a number of barriers that can make it challenging for an optician to communicate effectively with patients.[5]

1. *Expertise Imbalance*. Opticians have special training in their field. After years of training and experience it is easy to forget that patients may have little knowledge of these matters. Opticians need to constantly remind themselves of this disparity of expertise and explain things simply and clearly. Otherwise patients might not understand what is being communicated but may also feel as if they are being talked down to or being demeaned. This expertise imbalance may be affected by the internet in contradictory ways. On the one hand, the internet may allow patients to become better informed as they research information related to their concerns. However, this can result in situations where patients have received information that may be unreliable but causes the patient to become overconfident in their own knowledge and causes them to doubt the expertise of the optician.

2. *Power Imbalance*: Objectively, opticians are in a position of power in relation to their patients, although it may not always seem this way subjectively. Patients are approaching the professional person from a position of need related to a fundamental bodily function. As noted above, the optician has the expertise that the patient lacks. Positionally, the person in the relationship who is responsible for ensuring that everything is done correctly and safely is the optician. The optician is assigned the role of leading the communication. This means that the success of the communication rests on the optician.

3. *Emotional Imbalance*: Not only is the information communicated between the optician and the patient technical in nature, it also can have an emotional impact. Vision loss or impairment can be quite upsetting to many patients. For some patients, the visit is a reminder of the frailty of their bodies and even their mortality. Many patients may be concerned about how their condition will constrain their lives. For some patients there may be concerns about the impact of vision devices on their appearance. Some patients may be concerned about the cost implications of their choices. Patients on social assistance may be embarrassed about disclosing their financial condition. This emotional aspect to the communication can affect their ability to participate and understand what is being asked of or told to them.

4. *Personal Imbalance*: No one is perfectly well-adjusted. Both the optician and the patient have traits and circumstances that affect their ability to communicate.

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[5] Many of these points are made by Kathleen Vertino in "*Effective Interpersonal Communication: A Practice Guide to Improve Your Life*", The Online Journal of Nursing, 2014: Vol 3, No. 3; John M. Travaline, et. al, "Patient-Physician Communication: Why and How", Journal of the American Osteopathic Association, 2005: Vol. 105, No. 1; Wayne McKerrow, "*Improving Patient Care and Reducing Risk through Effective Communication*", Health Law Canada, 1997: Vol. 18, No. 1.

a. For example, if the optician has not developed a strong sense of empathy through their life experiences, they may interpret the communication only from their own perspective and not see things from the patient's perspective.

b. A patient's poor self-image could also create an unexpected reaction to their appearance (or comments on their appearance) when trying on frames.

c. An optician who was raised in an environment without clear boundaries may communicate in ways that make patients uncomfortable. For example, the optician may provide excessive self-disclosure by telling a "funny" story where they lost a contact lens, which may contain too much information about a private aspect of their lives. Patients can also initiate the crossing of boundaries such as in their expectations about seeing the optician outside of the dispensary or outside of normal hours.

d. Lack of insight can result in serious miscommunication. For example, an optician who does not have insight into their own impatience can make patients feel rushed, discouraging them from providing important information about their lifestyle or about a discomfort in the devices provided.

e. Physical or mental illnesses can affect communication. Obviously, a communication disorder, such as a hearing impairment, can have a profound effect on communication. Other conditions such as depression, anxiety and insomnia can also affect either the optician's or the patient's ability to focus and take in information. Where the optician is ill, they should ensure that their patient still receives treatment. Where the patient is ill, the optician should accommodate the illness appropriately (e.g., taking more time, rescheduling the visit).

f. Literacy and language levels vary dramatically from patient to patient. An optician should never assume that the patient can read or speak fluently and should always evaluate the patient's comprehension during the encounter.

5. *Cultural Imbalance*: Ontario is a highly multi-cultural society. Culture affects communication in fundamental ways. It is easy to misinterpret non-verbal communication (e.g., a reluctance to shake hands, different desires for personal space, use of eye contact) from the perspective of one's own culture when from the other person's culture, that non-verbal behaviour has other meanings. Roles also vary widely from culture to culture (e.g., behaviour towards authority figures, which an optician might be seen as being). This "authority figure" construct can affect the willingness of a patient to directly raise concerns about the fit or function of the vision device. Gender and parental roles can also be widely disparate (e.g., in some traditional cultures, the male is seen as the decision-maker). In some cultures, youths are considered as independent and are encouraged to make many of their own decisions while in other cultures parents retain a significant decision-making role until the youths are much older.

Opticians must be careful to recognize and address all of the imbalances that might exist that could impair the effectiveness of their communication with patients.

Strategies for Effective Communication

There are numerous strategies that can help opticians to become effective communicators. Some of them include the following:

1. *Accurate Promotion*: Ensuring that all of one's pre-visit communications are clear and accurate and initiate the communication on a solid footing. Advertising that truthfully describes the qualifications of the practitioners and the nature of the services provided, as well as a website that accurately portrays the nature of the assessment to be conducted and recommendations to be made all ensure that the optician-patient relationship does not begin with misconceptions.

2. *Meaningful Introduction*: When introducing oneself to a patient for the first time, consider what they want to know. Most patients wish to know the name and qualifications of the optician that will be helping them as well as some indication that the optician is interested in helping them. Using multiple forms of media to communicate one's name and qualifications can be helpful if the patient forgets (e.g., name tag, business card, staff directory on the wall).

3. *Listen First*: Most patients want to begin by explaining their needs and expectations. It is important to allow patients to do this in their own way and at their own pace. One study discovered that a physician will typically wait only 23 seconds before interrupting and steering the conversation.[6] While patients are unlikely to relay information in an organized fashion, assuming leadership of the conversation by interrupting from the start is not only disrespectful to the patient, but it will end the best opportunity to understand the patient's priorities. It can also send the implicit message that the optician does not want to know everything.

4. *Listen Intently*: It is said that people can think approximately four times more quickly than they can speak. Thus it is easy to be distracted by our own thoughts and we miss what is being said. It is important to focus on what the patient is saying in order to fully understand them. Assess the patient's non-verbal communication, such as facial expressions and body language, to capture the full meaning of what they are saying.

5. *Listen Actively*: Your patient can also think faster than they can talk. They are watching and considering your response to their words. Active listening such as nodding your head, maintaining eye contact and making reassuring or sympathetic noises tells the patient that you are listening to and understanding what they are saying. It may be appropriate for you to periodically summarize in your own words what you are hearing in order to ensure that you have understood correctly as well as to reassure the patient that you are listening. Making the patient wait unnecessarily, taking furious notes, looking away (or worse, turning away) while the patient is speaking demonstrates a lack of interest in what is being said.

6. *Describe the Dispensing Process*: Most patients, especially first time patients, are unfamiliar with the nature of the dispensing process. Some, based on ads they have seen, think it is like ordering a pizza: one hour or its free. Opticians should explain the components of the process

[6] John M. Travaline, et. al, "Patient-Physician Communication: Why and How", Journal of the American Osteopathic Association, 2005: Vol. 105, No. 1 at p. 15.

including information gathering, analysis, recommendations, preparing the vision devices, trialling them, adjusting them, dispensing them and post-dispensing adjustments. When patients understand what the optician is doing and why, they can better provide the optician with the necessary information and will have more realistic expectations.

7. *Assess What the Patient Already Knows*: Most patients have already seen an optometrist or ophthalmologist before entering the dispensary. They may have been to other opticians as well. Many patients research information on the internet prior to their visit and this information may be poorly understood or incorrect. On the other hand, some patients may know nothing about the topic before they walk in. Assessing what the patient already knows will help the optician enormously to identify information that needs to be clarified or corrected, as well as figuring out what information the patient does not yet know.

8. *Assess What the Patient Wants to Know*: Everyone is different. Some patients want very little information. Other patients want to know every detail. Allowing opportunities for the patient to ask questions, listening to the types of questions the patient asks and even asking the patient directly how detailed they would like you to be ensures that the patient pays attention to what you say and obtains the information they want. Of course there is some minimum information you have to communicate to the patient in order to obtain informed consent, but providing too much information can be counter-productive as well.

9. *Be Empathetic*: One cannot communicate effectively without seeing things from the patient's perspective. Conducting the meeting from the perspective of what you want to get out of it is self-defeating. Patients will feel that their wishes are not being considered. Not only will they shut down the flow of necessary information, they will be dissatisfied with the experience. If there are problems with the devices dispensed, a complaint is likely to follow, as we saw in the Sargon and Upeksha scenario. Expressing empathy involves a conscious effort as some emotions are conveyed indirectly by the tone of voice and body language. For example, a patient who is fearful of trying contact lenses even though it makes the most sense for them may not be willing to say so explicitly; it may come out through a lack of effort in learning how to insert them and through various demonstrations of frustration. It is possible to be at the other end of the spectrum and be over-invested emotionally with patients. This can lead to compassion fatigue and burnout. There needs to be a balance between showing too little and too much empathy.

10. *Cover the Necessary Topics*: There are certain topics that the optician needs to cover with the patient in order to meet their professional obligations and in order to prevent practical problems later on. Topics include informed consent, confidentiality and disclosure, billing and return policies, adjustment strategies, symptoms that indicate the patient needs to return and long-term maintenance techniques. It is also important to confirm with the patient, before they leave with the dispensed device, that you have met all of their goals and expectations. Using a checklist can ensure that this gets done. Making notes of the topics covered during the visit can also help ensure that everything is covered. Written materials can be very useful, but are never a substitute for verbal discussion.

11. *Slow Down*: Given the technical, sometimes emotional, and always important nature of the information being conveyed, it is often difficult for the patient to comprehend it all. Information

overload can cause the patient's mind to simply shut down. Speaking at a slow pace with frequent pauses enables the patient to understand what is being said and allows them the opportunity to ask questions. Periods of silence are not only acceptable; it is actually productive.

12. *Keep it Simple*: A companion to slowing down is keeping the communication of information simple. Long speeches can lose the listener. Short sentences that contain one concept at a time are helpful. Ensuring that the information is provided in an organized and logical order is also helpful. Avoid the use of technical terms, jargon and slang. Acronyms and abbreviations should not be used with patients. Use diagrams, props and written handouts to support and reinforce the explanation. Keep in mind that some people have low literacy and numeracy skills. Repeating key points may be important.

13. *Verify Understanding*: Silence does not equal understanding. The optician needs to verify that the patient understands the information. By listening to the patient's questions, one can evaluate how much they have grasped. Asking patients to restate what was said in their own words can be very helpful (e.g., "So tell me what you are going to do when you get home?").

14. *Interpret the Patient's Reaction*: One should look beyond the patient's reaction for what may be behind it. Patients who are stoical and do not show their emotions may still be concerned or worried. They may still want more information as well as the optician's encouragement and support. Frank displays of tears, denial or anger may indicate other stressors in the patient's life or perhaps mental illness, such as clinical anxiety. The optician should evaluate whether other circumstances need to be taken into account (e.g., delaying the trial of first contact lenses) or even whether a referral to another kind of health practitioner is indicated. Some patients may respond with distrust, anger and blame especially when the vision device is not working as hoped. Again, this response may not be truly related to the actions of the optician and may reflect other issues in the patient's life (i.e., displaced anger).

15. *Always be Professional*: An optician has the duty to maintain the professionalism of the relationship no matter how the patient behaves. Remaining calm, using professional language, demonstrating patience and working towards a resolution is expected. Lashing out at a patient is unprofessional no matter what the provocation. Even where the optician needs to take steps to protect themselves from physical or emotional abuse, this should be done with consummate professionalism. Never get angry.

16. *Stay Within Your Scope of Practice*: Opticians may wish to help patients in areas that are outside of their scope of practice. For example, opticians may wish to provide emotional or psychological counselling to patients. Such interventions may have the best of intentions and may be rationalized on the basis that the patient is unable to obtain assistance elsewhere or that the optician may be in a special position to assist (e.g., both are from the same socio-cultural group). However, in addition to the legal issues that this may raise, this intervention is inherently misleading. Even with a full disclaimer, the patient will almost certainly believe that the optician has special skills in the area which they do not have.

17. *Be Honest*: It is important to be encouraging and hopeful, but not at the expense of being honest. Do not minimize the level of discomfort, amount of effort or length of time it will take to achieve a goal. Doing so will ultimately discourage the patient or even cause them to give up. The same is true for the length of time it will take the lab to return something, the manufacturer to delivery something, the bottom-line cost or the amount that will be covered by insurance. Your credibility is essential to the confidence that this patient and future patients will have in you.

18. *Be Sincere*: Communication strategies need to be genuinely applied. The patient will notice if you are pretending to be focused or if you are faking empathy, which may cause the patient to lose confidence in you. Using disingenuous strategies to manipulate patients is a losing proposition. These strategies have to be implemented with commitment and integrity.

19. *Consider When an Interpreter is Needed*: Where there is a significant language barrier, the optician may need the use of an interpreter. Care must be taken when using a family member to ensure that the patient's privacy rights are respected and that it is the patient that is communicating the information and is making the decisions. It may be necessary to obtain the services of a more independent interpreter in some cases.

20. *Patients with Disabilities*: Opticians must accommodate a patient with disabilities. Where the patient has a communication disorder, the optician should consider how best to communicate with them. Asking the patient how you can better communicate with them is recommended. Some accommodations can be relatively simple, such as communicating in a well-lit area with no background noise. In other situations, the use of alternative means of communication (e.g., writing, computer) or an interpreter (e.g., sign language) may be needed. Never assume that a communication disorder equates with a cognitive disability. Always communicate directly with the patient even when using an interpreter.

Dealing with Conflicts

Opticians will inevitably have conflicts with patients, colleagues and third parties (e.g., physicians and optometrists who have issued the prescription). Conflict is not bad in itself and may be necessary in certain circumstances. Some conflicts can identify issues that need to be addressed and can provide alternatives, considerations and strategies for solving a problem. One's life experiences can create a negative attitude towards handling conflict that is difficult to modify. For some, conflict is comfortable and seen as productive. For many, however, conflict is uncomfortable because we have been taught that conflict is "bad" (e.g., we have seen it escalate to violence or abuse or we were not allowed to express our negative views). Whatever the background, opticians are expected to handle conflict professionally.[7]

[7] Many of these points are made by Kathleen Vertino in "*Effective Interpersonal Communication: A Practice Guide to Improve Your Life*", The Online Journal of Nursing, 2014: Vol 3, No. 3; Judith Brown, et. al., "*Conflict on interprofessional primary health care teams – can it be resolved*?", Journal of Interprofessional Care, 2011, No. 25; CM Patton, "*Conflict in Health Care: A Literature Review*", The Internet Journal of Healthcare Administration, Vol. 9. No. 1; Unknown, "*Explore the 5 Styles of Conflict Management & Resolution in Nursing*", The Sentinel Watch, posted July 27, 2011 on http://www.americansentinel.edu.

Conflicts can arise for many reasons, including differing interests (e.g., an insurer wanting to contain costs and a practitioner trying to help a patient), a lack of understanding as to the scope of practice of the optician, a lack of understanding of each other's roles (e.g., physician and optician), different views of who is accountable for the patient's welfare (e.g., prescriber solely responsible or each practitioner having some accountability and the team having shared accountability) and personality differences. Opticians should not assume that all conflicts are the result of personality clashes.

There are a number of barriers to resolving conflicts constructively, particularly where the conflicts involve the patient's health care team. These include the following:

1. *Time and Workload Issues*: Heavy workloads may leave team members without the necessary time and energy to address a concern. Unfortunately this can intensify the underlying issue (e.g., the patient's vision issues are not being properly addressed) and increase the frustration of all concerned.

2. *Power Differences*: Practitioners who fill the prescriptions issued by other practitioners have less power than those issuing the prescription. As such, they may not command the authority and respect necessary to have the concern addressed.

3. *Lack of Motivation to Address the Conflict*: A practitioner may not be willing to address a conflict on their own time (i.e., for free). Also, personality differences may create responses of defensiveness and anger such that one of the parties is no longer willing to communicate with the other.

4. *Fear of Causing Emotional Distress*: When there is an ongoing close working relationship (e.g., with a co-worker), a person may wish to avoid dealing with a conflict so as not to risk offending or hurting the feelings of the other person.

5. *Value Differences*: Where the decision in issue affects fundamental personal values, conflict can easily arise. This is presently occurring in the implementation of medical assistance in dying (MAID), where some practitioners feel they cannot participate in the process. These differences in value are not as common in opticianry, but they still exist. For example, there could be differences in values related to appearances and vanity or practicality and cost.

Some commentators have identified five different styles or approaches to handing conflicts:

1. *Avoidance*: This approach involves denying that the conflict exists and not dealing with it at all. There may be times when this approach can be appropriate (e.g., for a trivial matter or for a brief period of time until everyone has a chance to calm down), but most observers view this as a generally poor option. Often the conflict just builds up until another option has to be utilized.

2. *Obliging*: Yielding or accommodating the other party can be appropriate in some circumstances, such as where preserving the relationship is more important than the issue, or whether the issue means much more to one of the parties than the other. However, if used too often, it can taint the relationship or result in a build-up of emotion.

3. *Dominating*: Competing with the other person so that there is a clear winner and loser turns the conflict into a battle where the merits of the issue are lost. Pulling rank may be necessary in some circumstances (e.g., an emergency where decision action is necessary), but is harmful to the long-term relationship if used too often or without consideration of the substance of the issue.

4. *Compromise*: This involves bargaining and making concessions to resolve an issue. This approach may be useful where both sides have equal power and the issue does not warrant the expenditure of the emotional resources and time to solve. However, this approach often does not address the substantive issue, it may be inappropriate in some circumstances (e.g., where patient safety is in issue) and it may undermine the "values" of an organization.

5. *Collaboration*: Sometimes called "integration", this approach involves using a problem-solving approach where the competing interests and goals of both sides are stated and methods of resolving the situation to the mutual benefit of all concerned are sought. For example, where an optician is concerned about the appropriateness of an eyeglass prescription for an older patient, but the prescribing practitioner is concerned that the patient is not a good candidate to learn how to use contacts, a solution could be developed where temporary eyeglasses are issued while the optician undertakes to train the patient in the use of non-prescription contacts with the understanding that, if the patient becomes adept at using them, a prescription for contact lenses will be issued. Collaboration is time consuming and may not be practical for all conflicts.

Communication can assist in or detract from the resolutions of conflict. For example, using effective communication skills makes the collaborative approach more likely to be employed and more likely to succeed when it is employed. On the other hand, even if there is good will on both sides, using insensitive language can thwart the resolution of a collaborative resolution even where one is within reach. Similarly, using affirming and thoughtful language, even when employing a dominating approach, can reduce its long-term negative impacts (e.g., "I really hate to pull rank and normally I would sit down and discuss this with you, but this patient is leaving on holidays today so I would ask you to please help me adjust these frames now").

Understanding the barriers to conflict resolution, the various approaches to handling disagreements and the importance of effective communication skills in dealing with them, will help opticians in approaching conflicts wisely and successfully with minimal emotional damage to all concerned.

Conclusion

Effective communication is essential to a positive patient experience and a successful practice. There are a number of barriers to effective communication that need to be kept in mind, but by employing effective communication skills, those barriers can usually be overcome. Having an awareness of the barriers to managing conflicts and the various approaches for addressing specific conflicts can, with the use of effective communication skills, result in the most appropriate outcome for each conflict.

Chapter 4
Introduction to the *RHPA*

The *Regulated Health Professions Act* (*RHPA*) is the Act (or statute) that provides for the regulation of opticians. The *RHPA*, along with the *Opticianry Act*, establishes the duty and authority of the College of Opticians of Ontario to regulate the profession. The *RHPA* and the *Opticianry Act* also create the obligations upon opticians to practise competently and ethically.

This document describes the context in which the *RHPA* operates, outlines the duties and authority of the College and articulates some of the more significant duties imposed upon opticians.

Foundational Concepts

Some of the foundational concepts for understanding the *RHPA* include:

1. That "self-regulation" of a profession occurs when society enters into an understanding with the profession that the profession will regulate itself in the public interest;
2. That the *RHPA* is part of the legal system that includes other statutes, regulations, by-laws and case law;
3. That the College is accountable to many entities to ensure that its focus is on protecting the public; and
4. That the core regulatory activities of College include restrictive, reactive, proactive and transparent regulation.

Regulatory Framework – The Concept of Self-Regulation

Governments have options when deciding how an activity will be regulated. One choice is to not regulate the activity (say a health profession) at all. The market would determine which practitioners would succeed and which would fail. The civil courts could order the payment of monetary damages resulting from deliberate or negligent faults. And criminal courts would be available for any offences committed, such as assault or fraud. In Ontario, for example, estheticians and nail technologists are not regulated (like they are in some U.S. jurisdictions).

Another option is using consumer protection laws to require full disclosure, written contracts and cooling off periods and to prohibit unconscionable agreements. Where the practitioner does not follow consumer protection rules, the consumer has a number of remedies including rescinding the contract or taking the optician to provincial offences court. For example, fitness centres are subject to consumer protection laws.

Government regulation is a third approach. Governments regulate a number of activities directly through civil servants working for departments in a Ministry. For example, laboratories are regulated by employees of the Minister of Health and Long-Term Care ("Minister").

A fourth option is self-regulation where the registrants of a profession, working through a regulatory body, regulate the profession under a statute. That is the option, adopted in a modified manner, for the health professions governed by the *RHPA*.

Social Contract

The notion of self-regulation is that society and professions reach a shared understanding, which we sometimes call a "Social Contract". Society, through the government that represents it, enacts a statute for the regulation of the profession. The statute gives the profession a protected title, a recognized status and often some sort of monopoly over the performance of risky activities. In return the profession is expected to actively participate in its own regulation to ensure that the public is protected from harm or exploitation. While the social contract is a figurative concept, it is a picture that illustrates what everyone expects from the enactment of the statute.

Self-Regulation

In its pure form, self-regulation has three components. The first is that the registrants of a profession (in this case, opticians) select some of their colleagues to sit on the governing Board of their regulatory body. In turn, that governing Board selects opticians to sit on the various Committees of the regulatory body. Elected Board directors do not represent the opticians who elected them. They are not like politicians elected to city Council. Rather they are selected as respected registrants of the profession who are trusted to fairly and effectively regulate the profession in the public interest.

A second component of self-regulation is that the governing Board, made up of opticians, makes the rules that apply to opticians. As discussed below, those rules can take various forms such as regulations, by-laws, or written standards of practice. These rules are made to ensure that the public is protected.

A third component of self-regulation is that the governing body consults with the profession on a regular basis. The consultation ensures that the rules are appropriate and effective. The consultation also provides feedback to the regulator on how it is prioritizing and implementing its regulatory activities. For example, the profession could provide feedback on how a quality assurance program can most effectively enhance life-long competency.

One consequence of self-regulation is that the profession is generally expected to pay for the costs of self-regulation through fees charged to opticians. Increasingly, however, where government directly regulates a profession, it charges the costs of that regulation to the profession.

The actual provisions of the *RHPA* have modified the regulatory model so that it is not "pure" self-regulation. The College is accountable to the government, the courts and a number of agencies to ensure that it acts in the public interest. However, these three essential elements of self-regulation are still largely present.

Why Self-Regulation?

There are three main rationales for using the self-regulation model. The most commonly identified reason is that members of the profession have the specialized knowledge and expertise to understand how the profession really works, recognize the greatest areas of risk and know how to minimize the occurrence of those risks. For example, if a patient thought an optician had touched their eyes and face unnecessarily and the optician says the touch was part of the ordinary clinical care of opticians, who better than a panel of peers to listen to what happened and assess whether the touch was clinical or unwarranted?

Another rationale is that a profession is much more likely to accept and cooperate with a regulator if the profession selects the regulator's leaders than if the regulatory leaders are strangers to the profession.

For example, in order for the peer assessment component of the quality assurance program to succeed, opticians need to be open, candid and even trusting of the regulatory body. In fact, opticians are more likely to cooperate with the regulatory processes and even volunteer to participate in regulatory activities, such as being peer assessors, if they view themselves as part of the process.

A third rationale is that it is easier to make self-regulation accountable, transparent and responsive than it is for most of the other regulatory models. For example, if the profession were regulated directly by a department in the government, there would almost certainly be less openness, feedback and scrutiny of how decisions were made than we see today with *RHPA* Colleges. Similarly, there is no centralized source of information to evaluate the success of the consumer protection regulatory model.

Implications of Self-Regulation
Self-regulation can be ended by the government at any time. In fact, in most other countries where self-regulation of professions used to exist, such as England, the government has lost confidence in the regulator and has implemented a form of direct government regulation.

Another implication of self-regulation is that those involved in regulating the profession must "honour the bargain". It must always act, and be seen to act, in the public interest. Those involved in regulation must resist any urge to use the College processes to advance the interests of the profession.

As a result the perspective of those involved in regulating the profession must be relentlessly focused on how the College can best serve and protect the public.

The Public Interest

As mentioned above, the public interest is the central theme of professional self-regulation. The mandate, or purpose, of Colleges is to serve and protect the public interest. The difficulty, of course, is that the public interest varies depending on the circumstances. For example, a proposal to re-allocate a quarter of the complaints and discipline budget to the quality assurance program may or may not be in the public interest depending on the facts. Is the complaints and discipline process achieving its goals? Is there a backlog? Can its budget be cut without exposing the public to incompetent or dishonest opticians? Is the quality assurance program effective? Will an enhanced quality assurance program reduce the demand for complaints and discipline cases? How would the money most effectively be spent? Why not find additional money, perhaps by increasing fees, so that both are done at the same time?

The College is a regulatory body, created by statute to protect the public. A professional association is a voluntary body that is formed by opticians to advance the interests of the profession in some way. The mandates of the College and a professional association are completely different. Colleges find it valuable to consult with professional associations as a stakeholder. However, the College must make its decisions based on the interests of the public as a whole.

While it is impossible to give a comprehensive list of components of the public interest, the following are frequently identified examples:

1. Ensuring that opticians are and remain competent,
2. Ensuring that opticians act honestly and with integrity,

3. Ensuring that opticians are always sensitive to and aware of appropriate boundaries when dealing with patients,
4. Ensuring that the College performs its functions quickly; an excellent decision made slowly can be as unhelpful as a poor decision made quickly,
5. Ensuring that the College makes as much information as possible about its processes and its decisions available to the public so long as it does not unduly intrude on the reasonable privacy interests of individuals,
6. Ensuring that internationally trained opticians have their qualifications fully recognized so that they can contribute to health care in our diverse society, and
7. Fostering ready access by the public to the services of opticians.

Legal Context and Structure of the *RHPA*

Generally, laws are enacted by the government or made through court decisions.

Enacted laws are passed by different bodies. The highest level of enacted law are statutes (sometimes called Acts) made by either the Legislative Assembly in Ontario or the Canadian Parliament. Since the provincial governments are given authority over the regulation of professions, most statutes relating to the regulation of professions are enacted by the provincial Legislative Assembly.

Many statutes authorize the making of regulations or by-laws. Regulations are typically made by the government (i.e., the Cabinet), rather than the full Legislative Assembly. Regulations provide more specific details on how their enabling statute is to be implemented.

By-laws, a third form of enacted law, are typically made by delegated bodies, like the College and usually deal with administrative matters.

Enacted laws are hierarchical. Statutes take priority over regulations and both of them take priority over by-laws.

Independently of enacted law, courts make decisions. Those court decisions are legally binding and become precedents that guide future courts when dealing with similar matters.

Some people also consider standards of practice published by the College as a sort of law. For opticians, standards of practice guide their practice and can be the basis upon which they are held accountable for their professional actions by the courts or the College. However, since they are not formally enacted and are not court decisions, they are sometimes called “soft law” (as opposed to the other, “hard laws”).

The RHPA

The *RHPA* itself is a long and complicated statute. The first part of the *RHPA* deals primarily with matters external to the Colleges such as the powers and duties of the Minister. The second part deals with the operation of Colleges. It is called the *Health Professions Procedural Code*, or *Code* for short. This contains the provisions that set out the objects, or mandate, of the College. The *Code* establishes seven College Committees and allocates their tasks and powers.

Each profession has an additional specific Act that deals with matters unique to that profession. For example, a profession-specific Act has a "scope of practice" provision that describes the activities typically performed by opticians of that profession. It also sets out the titles that can only be used by opticians registered with that College (e.g., "optician") and the controlled acts assigned to that profession (e.g., dispensing subnormal vision devices). The *RHPA*, the *Code* and the profession-specific Act for each profession should be read as if it were one unified document.

RHPA Regulations
While all regulations made under the *RHPA* have to be approved by the Cabinet of the Ontario government, some are developed by the Minister and others are developed by the College. The regulations give more details about how regulatory activities of the College are to be conducted.

Minister-developed regulations deal with topics common to all Colleges such as the rules for health professional corporations. College-developed regulations deal with specific regulatory activities of each College. Proposed regulations must be circulated to the profession for comment 60 days before they are finalized by the Board. All Colleges have developed at least three core regulations: a regulation prescribing the requirements for registration with the College, a regulation defining what kinds of behaviour constitutes professional misconduct, and a regulation outlining the College's quality assurance program. The College of Opticians has also made regulations dealing with advertising rules, inspections and registration examinations.

RHPA By-laws
By-laws deal primarily with internal, administrative matters. For that reason they can be made by the College Board without the prior approval of the government. The more significant provisions, that affect opticians, have to be circulated for comment to the profession 60 days before they are enacted.

Some of the matters dealt with in College by-laws include the following:

1. The procedure for conducting elections of opticians to the Board;
2. The procedure for choosing College officers like the Chair and the Vice-chair;
3. The composition and procedure for selecting members of College Committees (subject to an over-riding regulation made by the Minister);
4. Identifying the additional information about opticians (beyond the minimum specified in the *Code*) that should be placed on the public register; and
5. Specifying the amount of all fees payable by opticians, applicants for registration and the general public.

Case Law
Case law performs two main functions. The first is to interpret the meaning and application of enacted law. For example, there have been a number of court decisions (e.g., *Sazant v. College of Physicians and Surgeons of Ontario*) that have explained the powers of an investigator appointed under the *Code* to enter into the business premises of opticians to inspect it and remove records and to summon documents from third parties. These cases also emphasize the duty of opticians to cooperate with an investigation.

The second main function of case law is to require that certain procedural safeguards be followed by Colleges when dealing with opticians. For example, the case of *Katzman v. Ontario College of Pharmacists* requires that the investigation of a complaint is confined to issues raised in the written complaint.

Accountability of the College, its Board and its Committees

In this context, the word "accountability" describes the systems and mechanisms in place to ensure that the College regulates effectively in the public interest. Accountability generally refers to forms of external scrutiny of the College.

Under the *RHPA* there is an extensive system of checks and balances to ensure that the College is focusing on its regulatory mandate and is doing so effectively. This accountability takes various forms and includes the following:

1. Structural accountability designing the organization of the College to combine professional expertise with the public interest (e.g., a balance of professional and public members on the Board and the College committees).
2. Political accountability to the Minister including making reports, providing information about the College's activities when requested and where there are significant concerns, appointing an auditor to review the College or a supervisor to take over its leadership.
3. Individual decision reviews by the Health Profession Appeals and Review Board (for registration and complaints decisions) and the courts (for discipline, fitness to practise and other decisions).
4. Program scrutiny that reviews the overall effectiveness of a College's activity such as the review of the College's registration practices by the Office of the Fairness Commissioner.
5. Direct accountability to the profession by the duty to consult with the profession on proposed regulations and by-laws, holding open Board meetings (with the meeting materials placed on the College's website) and through the election of the professional members of the Board.
6. Direct accountability to the public through operating a website that includes a public register on each optician and holding open Board meetings and discipline hearings and engaging in public consultations.

Together these accountability structures help ensure that the College fairly and effectively regulates the profession in the public interest.

Core Regulatory Activities of the *Code*

Colleges have seven statutory committees as required by the *RHPA*.

1. The Executive Committee coordinates the work of the Board. For example, it helps prepare the agenda for Board meetings. It also acts on Board's behalf on urgent matters between Board meetings.
2. The Registration Committee determines whether an applicant for registration meets the requirements for registration. Those requirements are set out in the registration regulation. Sometimes the Committee can grant exceptions where an applicant does not quite meet all of the requirements (with or without terms, conditions and limitations on the applicant's certificate of registration).

3. The Inquires, Complaints and Reports Committee ("ICRC") investigates complaints and other concerns about opticians. Where the concerns are substantiated, the ICRC has a number of options including taking no action, taking educational action (e.g., requiring completion of remediation), or referring the matter to a formal hearing when the concerns are serious.
4. The Discipline Committee holds hearings to determine whether an optician has engaged in professional misconduct or is incompetent. It can impose sanctions such as revocation, suspension, fines, reprimands and terms, conditions and limitations.
5. The Fitness to Practise Committee holds hearings to determine whether an optician is incapable (or impaired). It can impose orders to protect the public, such as requiring the optician to receive appropriate treatment.
6. The Quality Assurance Committee encourages opticians to engage in continuous professional development. Part of its task is to assess the knowledge, skill and judgment of opticians and to facilitate remediation where gaps are identified.
7. The Patient Relations Committee develops programs to encourage healthy interactions between patients and opticians. For example, it develops and implements a sexual abuse prevention plan within the profession.

The College can also have other standing and special-purpose committees created under the College's by-laws to perform specific tasks. For example, the College has a standing Governance Committee.

The regulatory activities of the College can be described as falling into four broad categories:

1. Restrictive regulation: limiting what people can do. For example, there are restrictions on the titles people can use, on who can perform controlled acts, and on who can become registered with the College.
2. Reactive regulation: responding to complaints and concerns about the conduct, competence and capacity of opticians.
3. Proactive regulation: designed to enhance the knowledge, skill and judgment of opticians.
4. Transparent regulation: providing information to the public about opticians so that the public can make informed choices about them. Transparent regulation also includes making many of the College's regulatory activities open to the public so that the public can have confidence that the College is acting in the public interest.

Each of these regulatory activities is discussed below.

Restrictive Regulation

Restrictive regulation means people are legally prevented from doing certain things unless they are registered because it would be harmful to the public if just anyone did them. A significant value in our society is freedom of choice. Governments will only limit free choice where it can be demonstrated that consumers are not in a position to protect themselves. Some examples of restrictive regulation include:

1. Protected titles such as "optician",
2. Controlled acts such as dispensing subnormal vision devices, and
3. Registration requirements such as requiring applicants to complete appropriate professional training, pass an examination and demonstrate their good character, before being permitted to be registered with the College.

Reactive Regulation

Reactive regulation deals with concerns about professional misconduct, incompetence or incapacity that comes to the attention of the College. The College may learn of the concern through a formal complaint, issues identified by another department of the College (e.g., an optician who is not participating in the College's quality assurance program), a mandatory report (e.g., from an employer), a voluntary report (e.g., from a concerned colleague), or information provided by the police or a media report.

Complaints

Perhaps one of the more well-known regulatory activities of the College is its handling of complaints. When a complaint is made to the College about the conduct of an optician, it is investigated by the ICRC. Both the complainant and the optician are given formal notice of the receipt of the complaint and a description of the process. The College tries to complete the process within 150 days. If the College requires more time, it must report regularly to the complainant and the optician about the delay.

The optician is given an opportunity to respond to it in writing. The optician is usually required to provide all relevant documents to the ICRC. The complainant is asked to comment on the optician's response to the complaint. Other witnesses may be approached for any information they might have. Documents may be obtained from third parties such as the patient's other health care providers. Where more information is needed, an investigator with additional powers can be appointed. For example, the investigator can attend at the optician's place of practice to review and copy records, summons documents from third parties or summons a witness to be questioned before a verbatim reporter.

Registrar's Investigation

Where there is no complaint in writing, the College can still investigate concerns through a Registrar's investigation. The initiation of the Registrar's investigation is approved by the ICRC. The report of the investigation (including any interview with the optician) is made in writing to the ICRC. The optician is given the results of the investigation and an opportunity to respond in writing. The ICRC then decides what to do with the Registrar's investigation report in the same way as it deals with a formal complaint.

ICRC Dispositions

The ICRC considers all of the available and relevant information to determine what to do about the concern. In some cases the concern has been explained and no action is required. In other cases the ICRC may conclude that the concern should be addressed by educational measures. For example, the optician could be asked to attend in person before the ICRC to be cautioned verbally. The optician could be required to complete a specified continuing education or remediation program (SCERP). Record keeping courses and programs in communicating with patients and colleagues are examples of remediation programs.

In serious cases, allegations of professional misconduct or incompetence can be referred to the Discipline Committee for a discipline hearing. Or if it appears that the optician is incapacitated, the fitness to practise process can be initiated.

Misconduct Regulation

Some types of professional misconduct are described in the *Code* itself. For instance, the *Code* makes breaking the law professional misconduct (e.g., to be found guilty of an offence relevant to an optician's suitability to practise the profession). Being found guilty of professional misconduct by another regulator

can lead to disciplinary action by the College as well. Sexual abuse of a patient is also listed in the *Code* as being professional misconduct. So is failing to cooperate with the quality assurance program.

However, the College's professional misconduct regulation describes additional examples of professional misconduct. The following are the main topics covered by the professional misconduct regulation.

1. *Standards of Practice*
   The professional misconduct regulation makes failing to meet the standard of practice of the profession professional misconduct. Usually, this relates to the assessment and treatment of patients by the optician. The standards of practice may be written, or unwritten. Standards of practice reflect a shared understanding of how opticianry should be practised effectively and safely. This is based on what would be reasonably expected of the ordinary competent optician in his or her type of practice. Expert witnesses are often used to describe a standard of practice and how it applies.

   One specific standard of practice in the professional misconduct regulation is that an optician must refer a patient to a physician where the patient has a condition that requires medical attention. For example, if a patient had symptoms that suggested a disease of the eye, the optician has to refer the patient.

2. *Inappropriate Behaviour towards Patients or the Public*
   Many provisions in professional misconduct regulation relate to inappropriate behaviour towards patients or the public. For example, in addition to sexual abuse, physical or verbal abuse of patients is professional misconduct.

   In addition, if a patient has a concern about an optician's conduct and wishes to make a complaint, the optician has a professional obligation to tell the patient about the College and how to contact the College.

3. *Record Keeping*
   Failing to make and retain appropriate and adequate records is professional misconduct. Part of the record keeping obligation is providing patients with the information contained (or should be contained) in their files. For example, a patient can request and obtain their pupillary distance measurements even if they intend to use that information for other purposes (e.g., making an online purchase).
   This is an important area to understand for opticians, so it is discussed in depth in its own jurisprudence chapter.

4. *Informed Consent*
   This regulation makes it professional misconduct to fail to obtain consent before assessing or treating a patient. As discussed in the jurisprudence chapter on boundaries, it is particularly important to obtain consent before touching a patient.

5. *Confidentiality*
   Opticians must keep all patient information confidential. Failing to maintain confidentiality can be considered professional misconduct. For example, collecting personal health information (e.g., their medical conditions and the medications they take) in an open area with other people around would violate the patient's privacy.

Another example would be if a patient requests glasses that look like their friend's (who is also a patient) glasses. One could easily end up in a situation where one is disclosing information about the other patient (e.g., the cost of frames purchased by the friend, the unsuitability of the frames for some prescriptions).

There may be exceptions to this duty of confidentiality. For example, patients can consent to the optician disclosing information. Also, where an optician is required (e.g., by a court order or a summons) or permitted (e.g., when selling one's practice) by law to disclose patient information, it can then be disclosed.

6. *Conflict of Interest*
   Opticians have a duty to act in the best interest of their patients. A conflict of interest arises when the optician is, or even appears to be, acting in their own or someone else's interest instead. For example, an optician has a duty to only refer patients to others where it is in the best interest of the patient. Referring a patient to a provider who confers a benefit (e.g., financial payment) to the optician is often a conflict of interest.

7. *Improper Billing and Fees*
   Opticians must be honest in their billings. Because of this, the professional misconduct regulation prohibits improper billing.

8. *Misrepresentation*
   It is professional misconduct to be dishonest in one's dealings with patients, colleagues, third party payers or the College. Dishonesty with third parties is also not acceptable (even if the intent is to help a patient). Third parties often assume that opticians are honest because of their professional status and rely upon their integrity. For example, it would be professional misconduct to issue a receipt for lenses in an incorrect amount, for a different family member or for a different date in order to facilitate insurance coverage for the patient.

9. *Improper Use of Names, Title or Descriptions*
   There are specific rules in the professional misconduct regulation that restrict use of certain names, titles or descriptions. For example, registrants of the College cannot use a term, title or designation indicating or implying that they have a specialization in an area or areas of practice unless the optician has been issued a specialty certificate issued by the College. Also, practising the profession under a name that is not registered with the College may be considered professional misconduct (e.g., if an optician uses a nickname when practising, the College must be formally told of that nickname first).

10. *Improper Advertising*
    It is professional misconduct to engage in false or misleading advertising. This would include the publication of anything that, because of its nature, cannot be verified (e.g., a testimonial of a patient, comparative or superlative statements like "best" or "most comfortable).

11. *Conduct towards Colleagues*
    Opticians must treat their colleagues with courtesy, respect and civility. For example, if an optician disagrees with the treatment being provided by another health care provider, the optician must not make insulting comments about the other health care provider to the patient.

12. *Conduct towards the College*
    Obligations come with the privileges of self-regulation. One obligation is that opticians must accept the regulatory authority of the College. Examples of conduct towards the College which can constitute professional misconduct include:

    a. Breaching an undertaking given to the College;

    b. Failing to cooperate in, or obstructing, an investigation by the College;

    c. Failing to participate in the quality assurance program; and

    d. Failing to respond appropriately and promptly to correspondence from the College.

13. *General Provision*
    The College has a general provision for professional misconduct. This covers types of conduct that are not specifically dealt with elsewhere and prohibits conduct that would be reasonably regarded as dishonourable, disgraceful or unprofessional. This provision assumes that there is a general consensus in the profession of the types of conduct or behaviour that would be considered unacceptable. For example, there is no specific provision that says that an optician has to provide a patient with the eyewear that they ordered and paid for, but such a refusal would be unprofessional.

Professional Misconduct Regulation Scenario

Sample Exam Question

Which of the following situations is/are possible professional misconduct according to the professional misconduct regulation?

a. Taking a patient's medical history in an open area with other people around.

b. Using verbal threats and insults to a patient in an email to them when they did not show up for an appointment.

c. Eyewear sold as prescription eyewear so a patient can claim it on their insurance

d. All of the above.

*The best answer is **d**. The regulation describes many types of professional misconduct. All of the situations described involve conduct that is specifically prohibited in the Professional Misconduct Regulation. Answer i), ii) and iii) are not the best answers because all of the situations listed in the question are clear examples of professional misconduct.*

Discipline Hearings
When a professional misconduct or incompetence concern is referred to the Discipline Committee, a full hearing is held. Formal allegations are prepared by the College and given to the optician. The College gives full disclosure of the relevant information to the optician. Both sides can hire lawyers, call witnesses and make arguments (often called submissions) to the Discipline Committee.

The Discipline Committee hearing panel has no prior involvement in the case. It makes an independent determination of whether the allegations have been proven by the College. The hearing is open to the public. Where some or all of the allegations have been proven, both sides tell the Discipline Committee what order they think would be fair. The order can range from a reprimand, a fine, and restrictions on practice, to a suspension or revocation of registration. Those types of orders can be combined. The decision of the Discipline Committee is summarized in the public register on the College's website. Either party can appeal the decision to the Divisional Court of Ontario.

Incapacity Inquiries
Where there is a serious concern that the optician may be incapacitated, or impaired, the ICRC can obtain information about his or her health. "Incapacity" is defined in the *Code* as an optician "suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the registrant's certificate of registration be subject to terms, conditions or limitations, or that the registrant no longer be permitted to practise." Typically incapacity concerns relate to addictions or certain mental illnesses that impair the judgment of the optician.

Incapacity is different from incompetence, which is also defined in the *Code.* Incompetence occurs when an optician lacks knowledge, skill and judgment to the extent that the restrictions should be imposed on their ability to practise in order to protect the public.

In incapacity matters the optician is often required to be examined by an independent health practitioner; typically a mental health professional or an addiction specialist. Where there is a serious concern that the optician may not be able to practise safely, the incapacity concern can be referred to the Fitness to Practise Committee for a hearing.

Fitness to Practise Hearings
Fitness to Practise hearings are similar to discipline hearings with a few exceptions. The allegations are about the current capacity of the optician to practise safely and effectively. Since the person's health is in issue, the hearing is closed to the public. Where a finding of incapacity is made, the most common consequence is a monitored treatment program.

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Reactive regulation has a high legal component. This is the area of regulation where lawyers are most frequently used. Reactive regulation can be an expensive part of the College's regulatory activities.

Proactive Regulation

Proactive regulation involves the College engaging with opticians when there are no specific concerns. The goal is to support opticians so that they enhance their practice. It can also be seen as fostering systemic changes to the profession (e.g., a change in the approach to a particular activity, such as

informed consent). Proactive regulation can also be viewed as preventative as it tries to anticipate areas where issues can develop if nothing changes. However, the underlying assumption of proactive regulation is that the vast majority of opticians are dedicated and conscientious. The College's supporting of these opticians (rather than focusing on a small number of opticians with concerns) can have a large and positive impact on the quality and professionalism of services provided to the public.

Quality Assurance Program
The best example of proactive regulation is the quality assurance program. The goal of the quality assurance program is to help opticians enhance their knowledge, skill and judgment. All opticians participate in the program.

Each year, opticians must complete a Professional Portfolio which requires opticians to reflect on their practice, enhance their competence and demonstrate continuous learning. As part of the Portfolio, opticians must complete a combined total of 16 continuing education (CE) hours annually[8], which includes:

- 4 Accredited Contact Lens (CL) Hours
- 4 Accredited Eyeglass (EG) Hours
- 4 Accredited Professional Growth (PG) Hours
- 4 Self-Directed CE hours

Opticians must also successfully complete the Jurisprudence and Sexual Abuse Prevention Self-Evaluation Tool once every three years. The tool is designed to help opticians maintain professional boundaries in their practice.

The quality assurance program is separated from the complaints and discipline process so that opticians can feel confident in candidly participating in quality assurance. An optician will only be referred to the ICRC if the optician does not fully participate in the quality assurance program or if serious concerns are identified.

Patient Relations Program
Another proactive regulation activity of the College is its patient relations program. For example, the program has a detailed plan to prevent sexual abuse of patients from occurring. The prevention plan includes education on the issue in the school training programs, providing learning resources for opticians and their employers and through public education. The completion of the Sexual Abuse Prevention Self-Evaluation Tool once every three years is part of this program. The Patient Relations Program is not limited to sexual abuse and can deal with other topics that help opticians interact constructively with patients.

Support and Education of Opticians
The College provides information and support to opticians to enhance their practices. The College provides alerts and information about changes to legislation or other laws that affect the practice of the profession. The College website has numerous resources and links for opticians as well as for members of the public. In addition, the College answers practice questions that are within the purview of the College.

[8] Opticians who have a refracting designation from the College are required to submit two additional CE hours specific to refraction (RF).

Proactive regulation is a major component of the College's regulatory activities.

Transparent Regulation

Expectations on regulators have changed in recent years. Part of almost any regulatory system today is providing information to the public. The public expects to know about the qualifications, registration status and any significant concerns about regulated opticians. In addition, the public is suspicious of secret regulation and expects to see regulatory activities take place in the open. A regulator can no longer simply say "trust us". The continual expansion of the accountability mechanisms for Colleges reflects the need for enhanced transparency.

Transparently demonstrating the fair and effective regulation of the profession can instill public confidence in the College. The disclosure of unfair or ineffective regulation of the profession undermines respect for the regulator.

Information about the College

Part of the transparency expectations is that the College makes information available to the public about its processes. The College strives to ensure that its website is readily navigable by both opticians and members of the public. The College makes efforts to ensure that the information is in plain language. As part of its openness, the College posts Board meeting materials in advance of Board meetings.

The College provides detailed information to opticians and the public about its regulatory initiatives. For example, the College consults with the profession and the public about any proposed changes to the College's regulations and most by-laws. Not only is this transparent, it also fosters feedback and better quality decision-making.

The College has to make a number of reports to accountability bodies including an annual report to the Minister and regular reports and filings with the OFC. In addition, when the Minister consults with Colleges, those communications are often posted on the relevant websites, including that of the College.

Public Register

Under the *RHPA*, the College is required to maintain a public register on all opticians on its website. This information helps the public (e.g., patients, employers) to decide whether to choose a particular optician. This information also helps the public to see how well the College is regulating opticians. In addition, the register helps ensure that opticians practise only as they are permitted by the College. For example, if an optician is suspended for three months, people can more easily report to the College if the optician is still working during the suspension period.

The register must contain the following information about each optician:

1. name;
2. contact information for each optician and, where applicable, the name of their health professional corporation;
3. the fact and date an optician died if known;
4. the contact information for health professional corporations;
5. the shareholders of health professional corporations (where they are opticians);

6. details of the registration categories of each optician;
7. the terms, conditions and limitations on each certificate of registration, regardless of their source;
8. a notation of any cautions and remediation orders issued by the ICRC;
9. details about any referrals to discipline;
10. a copy of any specified allegations of referrals to discipline;
11. the result of discipline and incapacity proceedings;
12. details of any acknowledgements and undertakings in force;
13. professional negligence or malpractice findings;
14. a notation of any suspension or revocation of registration;
15. a notation of any suspension or revocation of an authorization for a health professional corporation;
16. additional information specified by the registration, discipline or fitness to practise committees;
17. a notation of any pending appeals of disciplinary findings;
18. a summary of any outstanding charge or finding of guilt under the *Criminal Code* (Canada) or the *Controlled Drugs and Substances Act* (Canada),
19. any bail conditions,
20. any findings of professional misconduct or incompetence in any jurisdiction,
21. any license or registration to practise a profession in any jurisdiction, and
22. any resignation and undertaking given by the optician not to reapply in the face of a complaint or investigation.

The College's by-laws provide that additional information must also be placed on the public register, including the following:

1. An optician's refraction designation or contact lens designation;
2. Details of an optician's practice (e.g., areas of practice, languages spoken);
3. Address(es) and telephone numbers of an optician's practice location(s);
4. An optician's business email address;
5. Any nicknames or name abbreviations used by the registrant; and
6. Fact that there is a pending investigation where the public needs to know.

These by-laws are constantly changing as society's expectations about what information should be available to the public evolve. So opticians need to carefully read notices from the College about new information being added to the public register.

There are some circumstances where information can be withheld from the public. These exceptions include where the information is no longer relevant (e.g., old advertising infractions), where the safety of an individual was at risk (e.g., contact information where an optician is being stalked), where it includes personal health information (e.g., about patients) and after six years for minor discipline findings (e.g., where only a reprimand was administered).

Public Register Scenario

Bella, an optician, has separated from her husband. Bella's husband has hit her a number of times. Since the separation, Bella's husband has been following her. The police cannot seem to stop him. Bella moves to another city. She asks the Registrar not to put her business address or telephone

number on the public register so that her husband cannot find her. Bella provides documents from the police and the courts about her husband's behaviour. The Registrar removes Bella's contact information from the register.

Conclusion

The *RHPA* provides a detailed road map for the regulation of the profession in the public interest. Together with the *Opticianry Act*, regulations, by-laws and case law, the College is authorized to use various regulatory techniques to effectively and fairly protect the public including restrictive regulation, reactive regulation, proactive regulation and transparent regulation. Opticians need to be aware of the professional obligations that apply to them including the various types of professional misconduct to avoid. Maintaining public confidence is essential to preserving self-regulation of the profession as well as the reputation of the profession.