

# focus

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 Ontario Opticians Association

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“The Official Voice of Ontario Opticians”

## President's Message

By Ali Badreddine, RO

**I would like to begin by wishing everyone a happy and prosperous new year.**

### Welcome our new Office Administrator

I'd like to take this opportunity to introduce you to our new office administrator, Karin Sheppard. Karin comes to us with a wealth of experience in a variety of fields, and over the last few months she has proven to be a great asset to the association.

### Inside Optics hosts most ever registrants

2007 was also the last year of the 3 year con-ed cycle and the OOA responded by organizing two Inside Optics weekends. The first one was held at the end of April and over 1000 Ontario Opticians attended the two-day event. The Saturday night dinner dance was also well attended and over 200 people participated in honoring the Optician of the Year alumni.

Inside Optics “last call” held November 11th, was the most successful Inside Optics to date. In one day over 550 members and 84 non-members were in attendance to make this the largest Ontario Opticians' gathering ever. It's rewarding that Ontario Opticians are starting to come out to educational events even when they don't need to collect credits. I believe this is a sign of positive commitment to the profession and to personal growth.

### OOA puts your membership dollars to work for YOU

Our membership is growing faster than ever and we expect this trend to continue. Most Ontario Opticians now recognize the value in being a member of their provincial and national associations. For those few who have not yet made a commitment, I realize at this time of year you have to make choices about where to spend your money and your energy. I urge you to judge the Ontario Opticians Association on its record as a non-profit organization working exclusively for you.

- There are many special interest groups within the optical community but none aside from the OOA that dedicate their funds, their energies and their goals only to Opticians.

The OOA does not invite membership from other practitioners in the vision care field as some do. Although there are overlaps in scope of practice and education, Optometrists and Ophthalmologists have a different political agenda than Opticians. As an organization that lobbies intensely for your best interest we would be severely compromised if we had a mixed membership. We believe in YOU.

- The OOA Board of Directors volunteer their time at some personal cost because they believe in the future of the profession and they want Opticians to prosper. Any funds collected by the OOA through membership or sale of product goes directly to our legislative and continuing education efforts. You don't have to guess how your membership dollars are used. The results are transparent.

- Our goal of providing free continuing education has started to be realized. We continue to work with our OAC partner to innovate new ways of providing continuing education for those of you who are unable to attend our Inside Optics events. Look for news of more online opportunities in this New Year.

- The OOA continues to meet with and monitor the activities of the College of Opticians of Ontario. We respond to and comment on every draft policy and Standard of Practice the College circulates. Our submissions are frequently critical but we believe the best way to get things changed is to work with people constructively. I urge you to read all of our submission to the College which appear on our website.

## Standard of Practice for Refracting Handicaps Refracting Opticians

With great pressure from the Ontario Opticians Association (OOA) the College of Opticians of Ontario (COO) lifted the ban that was placed on opticians being able to refract. This was a move the OOA has been urging the College to make for many years. Although establishing a Standard of Practice for Refracting is a step forward, we feel it still doesn't do enough to enable Ontario Opticians to be where they need to be.

In fact in some significant ways the Standard places unreasonable handicaps on Refracting Opticians. An analysis of those issues is outlined elsewhere in this newsletter.

The OOA's push toward a more sensible standard continues.

### Public Relations

Last year was a provincial election year in Ontario. The OOA board members worked on a campaign to try and meet with every candidate that was running for election and to lobby their support for the Ontario Opticians goal of performing stand alone refraction. We were gratified to receive letters of support from several candidates including the former Minister of Health who instructed the College to impose the ban – Elizabeth Witmer. All the letters can be seen on our website [www.ontario-opticians.com](http://www.ontario-opticians.com).

We are not finished with this campaign; we are still meeting with newly elected MPPs and trying to convince the government that expanding the scope of practice for Ontario Opticians to include stand alone refraction is beneficial to all Ontario residents.



Ali Badreddine, RO

## Standard practice for Refracting - the Good, the Bad, and the Ugly

By Ali Badreddine & Mary Field

Both the Ontario Opticians Association and its partner, the Opticians Association of Canada has submitted comment to the College of Opticians of Ontario on its recently published Standard of Practice for Refraction. At the outset we note the COO's acknowledgement that this Standard does not reflect what the OOA believes to be the needs of Ontario Opticians. This Standard takes us back to where we were prior to the imposition of the ban. What Ontario Opticians are looking for is independent refracting.

The Standard is not without it's good points but it unfortunately includes requirements that are bad and in some cases downright ugly.

### The Good

- Many believed that the ban should have been lifted several years ago. Once it became clear that a Standard could not be developed in collaboration with the College of Optometrists of Ontario and the College of Physicians and Surgeons as the Minister of Health had recommended, the College of Opticians of Ontario should have moved quickly to develop a Standard of Practice on its own and moved forward. However, the COO has finally done what it should have done 5 years ago. A little late but nevertheless a move forward.

### The Bad

- Opticians have reported confusion over the difference between the scenarios contemplated in this clause. There is simply not enough information on how each of these scenarios would be applicable in a practice setting. We suggest that there is sufficient uncertainty over what differentiates the three conditions to warrant an instructional seminar from the COO. The OOA has offered to organize and coordinate regional seminars in collaboration with the COO to answer your questions.

- On page one of the COO's Background Document it states "Opticians may not begin to refract until an application has been approved by the College." There are many Ontario Opticians who have already taken the Refracting-training program at Georgian College or other refracting courses and may well be ready to apply to the College. We were unable to find an application on the College website nor amongst the documents that have been broadcast to stakeholders. In fairness the College should have prepared all necessary documentation and applications so that Ontario Opticians could resume providing refracting services under the new Standard.

### The Ugly

- The Standard states that the individual must have had an eye health examination within 365 days in order to qualify as a candidate for Optician-performed refracting. This is ridiculous as it presents an unrealistic handicap for Refracting Opticians wishing to provide timely service for clients. It also forces additional expense on consumers. There is no consistent opinion of Eye Care Practitioners on the recommended frequency for eye health examinations but all sources agree that frequency is based on factors specific to the individual.

The Canadian Ophthalmological Society's (COS) recently published an evidence-based document that relies on age and other risk factors to determine the recommended frequency of eye health examination. This does not include an automatic yearly eye health examination. The 365-day requirement is one of optometric design and should not have been endorsed by the COO through its Standard of Practice.

- The OOA objects to the requirement that the Refracting Optician send to the authorized prescriber not only the results of the refractive error but information on the optical appliance. We believe that a referring practitioner is entitled to the results of the refraction as it forms part of the patient's medical records. Where the authorized prescriber is an Optometrist – however unlikely that scenario might be – the Refracting Optician would be required by the COO to deliver into the hands of a competitor proprietary information. This requirement goes beyond what is necessary to protect public interest.

**We question the rationale used by the Standards Committee in making these two requirements part of the Standard of Practice. Both stipulations work to the commercial advantage of optometrists; both place an unrealistic handicap on Refracting Opticians and do nothing to protect the safety of consumers.**

#### **Good and Ugly**

- The concept of collecting and analyzing data developed via the Patient Consent Form is a good one. The Patient Consent Form is well thought-out and provides the Refracting Optician with an appropriate tool to develop that data. It is important that we have empirical data to support our further ambitions for independent refracting. Unfortunately the unnecessarily restrictive nature of the Standard will discourage and even prevent many Opticians from re-instating or initiating a refracting service. Consequently any data gathered will give a false impression of the need for and the benefits of optician-performed refracting.

The OOA continues to be disappointed that the COO policy and standards committees do not include stakeholders in the developmental stages of their documents. Instead they spend a lot of time producing drafts for stakeholder critique then, for the most part, they ignore that critique.

## **Student Corner Past, Present, Future by the Numbers**

By Sasha Roudak, Seneca College Student Rep,  
OOA Director

Three years ago I submitted my application through OCAS hoping to get into the Opticianry Program at Seneca College. At the time I was already working in the industry and wanted to get my license and start a career. Simultaneously, I applied to two other colleges for various part-time courses. Finally, after receiving acceptances for the programs I wasn't really interested in, Seneca sent me an invitation to write an admissions test to evaluate my English and Math skills. A few weeks later I was enrolled in the 4 year part-time program. Had I known then that there was an option to take a shorter, accelerated program at Seneca, I would have been licensed now.

With over 300 applications each year, Seneca's Opticianry Program is over-subscribed. Some applicants do not have Seneca as their number one choice having applied for other programs, for instance, the full-time program at Georgian. Others do not meet all the requirements, which include Grade 12 English and Math, and any Grade 12 Science, such as Chemistry, Biology or Physics. Seneca College accommodates as many new students as possible based on the admissions exams and working experience in the Optical industry.



About 75 first-year students were enrolled in the Opticianry Program at Seneca College last September. This is a decline from the previous years, setting the number more in-line with industry needs. Close to 40 graduated last year. This number does not imply a high drop-out rate, as it excludes students who graduated ahead of their classmates due to advanced standing or those who stayed a year behind to catch-up or re-take a failed subject. Some of the students moved to study in British Columbia in order to graduate faster or because they found the program at Seneca too demanding.

Seneca College is now offering a two and a half year part-time Opticianry course in Ottawa. This is an accelerated program, which students in Toronto seem to be unaware of. It seems highly unlikely that a large percentage of students would not opt to spend half the time to obtain their licenses if they were aware that there was a possibility of finishing the course in Toronto in just over two years. It feels like there is a communication gap between Seneca at Newnham Campus and its students.

The Opticianry Program at Newnham offers a variety of classes, including Physics, Anatomy and Pathology, glasses and contact lens labs and theory, and teaches students all aspects of the profession. General interest subjects help those in need of communication, computer and selling skills. A thousand hours of field placement is also required to be completed throughout the program, so the employment rate is extremely high at graduation. After leaving Seneca, new opticians are ready to take on anything the future throws at them.

A growing number of BC opticians transferred their licenses to Ontario over the last 4 years. Some have the same education level as those graduating from Ontario colleges, but some have only taken the 6 month course. Last year there were 109 newly registered Opticians in Ontario of which 44 were BC opticians. Opticians in this province have tried for years to maintain a high education standard to graduate knowledgeable and competent professionals. We have to ask ourselves if there is a way to standardize the level of education and ensure the future of the profession.

You can e-mail Sasha at: [sasha\\_roudak@hotmail.com](mailto:sasha_roudak@hotmail.com)

## In Memoriam: Norm Eggett

It is with great sadness that the Ontario Opticians Association announces the passing of Norman William Eggett. Norman William Eggett was in his 70th year. He passed away peacefully Friday, October 19, 2007 at Parkwood Hospital Palliative Care Unit, London.

At age 15, Norm left school and his family home to work for Paul Smith Sr. on the London Market; this was followed by numerous experiences in the retail industry. At the age of 29, Norm went back to school and successfully received his opticians' licence. After working in Toronto for a few years, Norm and Joan moved the family back to his home town of London to establish Eggett Optical in Wellington Square Mall (1973).

He loved being an optician, the people he encountered and the experiences he had while running his business. Especially memorable were the numerous trips with Dr. Charlie Thompson to Moose Factory and the Baffin Islands, to fit the Inuit people with eye glasses in their own environment. Norm was a member of the Executive of the College of Opticians of Ontario and was recognized by the Ontario Opticians Association as a Honorary Lifetime Member.

Norm is survived by his beloved wife Joan and his children Wade, Stephen, Lauren and Brad. Our deepest sympathy goes out to his family and friends.

## New Corporate Partner

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# Continuing Education Opportunity Clinical Refraction – An Essay

By Geoff Briede, RO

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In the past I've written about the artistic part of a clinical refraction; some of which is prompting the subject to give you the answers you need in order to produce a comfortable and useful spectacle prescription for them, without annoying or tiring them out beyond reason.

Today, though, I am going to write about the scientific part of the process. This essay, it should be noted, will fall far short of a complete description of a clinical refraction; there is simply not enough copy area allotted to this essay. Therefore, no mention will be made of the techniques for measuring refractive error, reading additions, extra-ocular muscle imbalances, convergence insufficiencies, cover-uncover/cross-cover testing or the many and varied ways of dealing with cases of diplopia or tropia and other situations; some of these will be covered, hopefully, in subsequent essays. This essay should be considered a general overview and an introduction to the logical thought processes involved in an everyday clinical refraction.

The human eye is a truly remarkable example of engineering and design excellence. Just imagine if the radius of curvature of your OD's cornea varied from that of the OS's by the same magnitude as, say, your two thumbs vary from each other. You'd have one eye that was 6 or 8 (or even more) dioptres of difference in resolving power compared to the other. The tolerances where the eye is concerned are so very tight that it really is a marvel that so many pairs of eyes "out there" are within a 0.25D or 0.50D of one another. When one considers the number of refracting surfaces involved – from the anterior surface of the tear film all the way back to the posterior surface of the vitreous – and how much power a difference of 0.1 mm in the radius of curvature of any of those surfaces can generate, it is a truly spectacular thing to have so many pairs of eyes in the world that are not only exactly the same power as one another, but also the exact power that produces emmetropia. And yet, statistically at least, there is no shortage of pairs of eyes that fall within that "perfect" category.

At this point I suggest you drag out your old notes from school and review Gullstrand's Schematic Eye; it is this state of perfect vision that one needs to become intimately familiar with in order to be a good refractionist.

In a nutshell, emmetropia means that all axial lengths and refractive powers combine perfectly, causing light from an infinite source to come to as sharp and precise a focus on the retina as is possible. Hypermetropia means that the eye is lacking enough resolving power and needs more; myopia is the opposite; the eye has too much power. There is also astigmatism to consider; these are refractive errors brought on by non-spherical surfaces, by toric surfaces, surfaces with two different curvatures at right angles to one other.

The effective refractionist measures this under- or over-abundance of power with a series of objective and subjective techniques. He/she finishes with a statement of lens powers which, if brought to bear by the spectacle/contact lens designer and/or manufacturer in an optically correct way, will result in light from an infinite source being brought to a perfect focus on that person's retina.

Now for a word about that refractionist: no two refractionists will produce the same results on the same patient. I would be willing to bet that if, by some future technique you could clone yourself and all your knowledge, and you were to refract a patient and subsequently send in your clone five minutes later – say with a different coloured shirt on – your clone would also come up with a difference of a 0.25D here or there, perhaps a few degrees on one or both of the axes of the cylinders. This is the artistic part of the process; how the patient reacts to your queries; how the patient reacts to your wardrobe, maybe (!?! no one really knows); what the patient's state of mind was upon entering the lane; what your state of mind is that day. Human beings are not machines; indeed, if patients were more machine-like it would be a much simpler world, not to mention colourless and boring, and refraction and the correction of visual defects would be a lot less work.

Soon into your studies you will realize that sometimes, with the odd patient, you will come up with a spectacle prescription that they cannot wear, or that they "don't see as well as" they do with their old glasses. The way to ensure this situation doesn't occur too often is to approach the process of clinical refraction as though it was a puzzle; with pure logic at the beginning and then, as more pieces fall into place, a combination of logic and intuition. Even if you do everything perfectly, however, you're still going to have unsuccessful refractions; get used to the idea now so that when such a case does come along you can deal with it as efficiently and as economically as possible, and with a minimum of bruised feelings for both you and – more importantly – your patient. Ultimately, your patients will decide who's right; they'll tell their friends too.

The first step in solving the puzzle is to get as much information about the subject as you can, which means asking questions of the patient to elicit what kinds of visual problems they are having. This would be analogous to looking at the picture on the front of the puzzle box. The analogy holds up well too; just like when building a puzzle, one continually refers to the picture on the front of the box to identify pieces. During the refraction process, the refractionist keeps the patient's chief complaint in mind and, as data accumulates, a pattern should emerge. If the complaint's ramifications and the data you're accumulating don't start to converge, or "jive" in the expected manner, you can pause for a moment and reconsider – perhaps ask another question of the patient – even re-examine your original premise. This is preferable to your beating your head against the wall, trying one lens combination after another in hopes of stumbling upon the correct one.

## **So, get as much information as you can before swinging the phoropter into place, or placing that trial frame on the patient's face.**

- 1) Patient's history**, including all visual complaints and relevant medical info; dry eyes often cause blurry vision, so medications known to affect the tear film are key considerations, as are systemic conditions causing inflammation of tear-producing structures or those that effect the globe, or part of it, in any way
- 2) Patient's visual acuities**, with current correction, if any – both at distance and near point - also chart and consider uncorrected/unaided visual acuities; a person who scores only 20/40 mono OU with a pair of +1.00 DSPH "distance" glasses

and then manages 20/20 mono OU unaided, might just point you in the right direction before you even begin to refract.

Older patients often get their opticians' instructions mixed up and wear the wrong glasses for the situation they're in. Also, pay particular attention to a patient's head position when they're reading the Snellen chart; a patient who tips their head back so they're using some of the progressive corridor to see at a distance can throw you right off the track – make sure they use the distance portion of their lenses to read at the 20 foot range; you can always have them tip their head back after you chart the correct findings, to see if it indeed gives better acuity – and if it does, half of the puzzle is already solved: there is an extremely high probability that they need more plus (or less minus) in their new prescription.

If the glasses don't fit properly, adjust them so they are looking out of the correct part of the lens; there is no single piece of data you can obtain during a refraction that is more important than how well they're seeing with what they've already got. I will write more about this point a little later in this essay.

**3) Neutralize patient's current optical appliances;** if they bring half a dozen pairs of glasses, neutralize as many as you need to, to build a coherent picture in your mind of what's been done in the past for this pair of eyes.

**4) Retinoscopy,** manual or computerized (auto-refractor) also provides valuable data that is not subjective and, because of this objectivity, can give you a useful touchstone to compare your subjective findings to; human beings are not always the best source of data. Keratometry, too, can alert you to an increased probability for astigmatism testing/correction and even suggest which axis quadrant is best to start looking for it at; so if you've got an auto R/K unit, by all means, turn on the "K" part of it too.

It is generally accepted that performing an ocular refraction in a darkened room is preferable to a well-lit one, and there is good science behind these opinions: the first point is that sitting in a darkened room will cause one's pupil to dilate, thereby minimizing the "pin hole" effect a small pupil can create. To fully appreciate how much an eye's resolution is improved through a pin hole, take any patient (or yourself, if you fit the criteria) whose spectacle prescription is 4 or more dioptres, in either direction, and measure the visual acuity of their OD (occluding the OS) with their glasses on. Now remove their glasses, occlude the OS and ask them to hold a pin hole in front of their OD, and see how far down the chart they can read; if you've never performed this procedure before you might be surprised to find that they have only lost a line – sometimes two, sometimes none - over what they can perform with their full Rx in place.

Experienced refractionists will often "pin hole 'em" when they are wondering how much resolution a particular eye is capable of; a pin hole will often enable a severe ametropes (assuming no media opacities) to resolve images almost as well as with their best possible spectacle correction. This is a useful and quick test which will furnish you with a visual acuity target to work toward, and even work beyond – if it's possible. The second reason for using a darkened room is that most refractionists find coping with accommodation (the nemesis of the refractionist) quite a bit less difficult in a darkened room; this is because the same muscle group that

controls the iris also regulates tension on the suspensory ligaments (the zonules of Zinn) of the crystalline lens. Presumably, relaxing a muscle is far less difficult if the other muscles in the group, or those attached, are likewise relaxed – it makes sense. Remember, sphincter muscles are fully open only when fully relaxed, the tension on the crystalline lens is greatest when the muscle is fully opened, meaning the lens is being pulled as flat as it can be, thereby exerting the least amount of + power it is capable of. And this is exactly the situation you need to get an accurate and comfortable-to-wear refraction result.

Before I run out of room in my allotted 2000 words I want to write a little about what my experience tells me is an extremely important part of a clinical refraction. This is the end point balance test; it would be more accurate to say "tests" as there are several subjective ways to determine if you have balanced your spectacle prescription properly. By this I mean, with all the techniques one can bring to bear to relax and remove from the equation the accommodation response of the human eye, one is never quite sure if one was entirely successful.

Indeed, with the vast majority of your refractions I think it is safe to assume that you absolutely did not completely relax the subject's accommodation – especially if that subject is 40 years old or younger. But here's the important thing to remember: in the vast majority of cases it is far more important to relax the accommodative response equally between the two eyes, rather than entirely. In other words, since you are incapable of completely relaxing the accommodative response, it follows that the subject is quite comfortable exerting some accommodation all day long – but if you want to make the glasses comfortable to wear you must make sure that the amount of accommodation that subject is exerting all day long is the same in both eyes. The vast majority of people simply will not be able to wear a pair of glasses that requires that their OD exert +0.75D of accommodation while the OS exerts +0.25. In fact, barring some injury, pathological defect or 35 years of practice because of a succession of poorly balanced prescriptions, it is theoretically impossible for the human accommodative system to do so.

*Having said that, I once had a patient who, after a cycloplegic refraction, was shown to have an imbalance of 2.50D in his prescription; he had no defects (that we could determine) or injuries - and what's more - he liked wearing those glasses. This just goes to show you that regardless of how much science and logic you throw at a human being – they can throw you a curve when you least expect it. All you can do is laugh, shrug it off, and have another stab at it.*

Familiarize yourself with the many different ways of subjectively coming to an end point balance to your refractions – it never fails to amaze me how a little imbalance – say, a 0.25D – in a person's refraction can cause headaches and/or blurry, fluctuating vision. This is by no means a full and complete list of complaints associated with prescription imbalance, just the most often mentioned by patients.

At the very end of the procedure the refractionist has to go right back to the beginning to look at one of the very first pieces of data he/she acquired: the visual acuities the patient came to you with. Whether with or without glasses you must pose the question

to yourself: "How much improvement over their current state am I able to offer this patient?" Bitter experience has taught me – particularly with the elderly or people who resist every change energetically – that unless you can offer at least a two line improvement on one of the eyes (preferably both) the vast majority of patients will detect no difference, or come to the conclusion that their old prescription is better. At the very least, they will resent spending "X" number of dollars on a new pair of glasses they "didn't really need." This is why in clinic we used to have a rule: "A two line improvement in at least one of the eyes warrants a clinical recommendation to change their prescription; lesser improvements become optional and at the patient's discretion."

You can even help the patient to make that decision; have the patient fixate on the smallest line they are able to read with your new refraction, asking them to note how sharply it seems to be focussed, then quickly swing the phoropter out of the way and place their old glasses back on their face, telling them to look at the same line. Let them decide if the small improvement you've uncovered is worth the cost of new lenses/glasses. Some people will willingly spend hundreds of dollars to garner a slight improvement; deer hunters come to mind. Still others will "leave it until next time."

The ethical and effective refractionist must always consider the sensibilities of the human on the other side of the phoropter; not just the function of that person's eyes, but the entire package.

You can e-mail Geoff at: [geoff.briede@gmail.com](mailto:geoff.briede@gmail.com)

### **The OOA is pleased to offer you this FREE Con-Ed Accreditation Essay at no cost to our members.**

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#### **Ontario Opticians Association**

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**Note of Interest:** The Canadian Ophthalmological Society (COS) recently released its evidence-based clinical practice guidelines for the periodic eye examination of adults in Canada. Over the next 24 months, COS intends to undertake a similar process to develop guidelines on cataract, glaucoma and macular degeneration.

For more information visit:  
<http://www.eyesite.ca/english/index.htm>

## **Seneca and Georgian Students received Opticianry awards from the OOA.**

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**Darra Salina** from Seneca is the 2007 recipient of the Shelley Dewell Memorial Award of Excellence. Presented by the Ontario Opticians Association, the award recognizes outstanding student achievement in Seneca's Opticianry program.



**Francesca Merlo** from Georgian is the 2007 recipient of the Ontario Opticians Association Student Achievement Award. The Award recognizes outstanding student achievement in Georgian's Opticianry program.

*Francesca Merlo Marcantonio received her award from Janice Smidtt.*

## **Interesting Findings**

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Competition Bureau releases report on self-regulated professions including Optometrists. While there are numerous self-regulated professions in Canada, covering a wide range of service, this study, focuses on five professions: Accountants, Lawyers, Optometrists, Pharmacists and Real Estate Agents.

Over 18 months, the Competition Bureau conducted extensive research of these professions, soliciting input from provincial and territorial regulators through a questionnaire and holding follow-up consultations on their findings. The Ontario Opticians Association took part in the study.

Read what the Bureau has to say about Optometrists, on the Competition Bureau website at [www.competitionbureau.gc.ca](http://www.competitionbureau.gc.ca).

## COO Statistics/2006 Annual Report An Aging Population of Ontario Opticians

By Rick Hayward, RO

The recent COO 2006 Annual Report reveals some alarming figures about where the workforce of opticians will be in the next ten to fifteen years if we don't ramp up promotion of our profession as a career opportunity.

If you consider the statistics found on pg.29 of the COO document:

- 24.3% of COO Members are 50 - 59 years of age
- 8.6% are between 60 and 69 years of age and
- 62.2% of COO Members are between the ages of 40 and 69
- 9.3% of the COO Membership are in the range of 20 and 29 years of age
- 23.5% are between 30 and 39 years of age

This means that potentially 50% of the COO Membership could leave the profession through retirement in the next ten years. What would this mean for the profession?

It would mean that there would not be enough licensed opticians to staff the hundreds of dispensaries in Ontario.

The mandate of the College is to ensure that the public is protected and part of that protection is to require every dispensary to employ licensed personnel. But...you can't get water out of a stone. You can't enforce your regulation if it becomes unrealistic due to lack of manpower.

Our teaching institutions need to be producing more candidates for licensure. But both the College and the Associations need to take steps as well to publicize the profession as a career opportunity. Individual opticians have a responsibility as well. Let's get out into the community and speak at career days.

Let's network with school counselors to encourage interest amongst their students. Let's consider having a work experience day in our dispensaries... have the counselors identify students who wish to find out what it's like to be an optician, spend the day shadowing a dispenser. Our profession is worth the effort.

You can e-mail Rick at: [mrhayward@sympatico.ca](mailto:mrhayward@sympatico.ca)



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Begin a fulfilling career with one of our major retailers such as LensCrafters, Pearle Vision or Sears Optical, where you will take pride in delivering outstanding customer service and quality eyewear.

If you are interested in creating exceptional value in the lives of your customers please fax your resumé to 416-620-7467. Luxottica Retail provides extensive on-the-job training and a competitive compensation package.

**For more information visit our websites at:**  
[www.lenscrafters.ca](http://www.lenscrafters.ca); [www.pearlevision.ca](http://www.pearlevision.ca) and  
[www.canadaoptical.ca](http://www.canadaoptical.ca)

LENSCRAFTERS

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