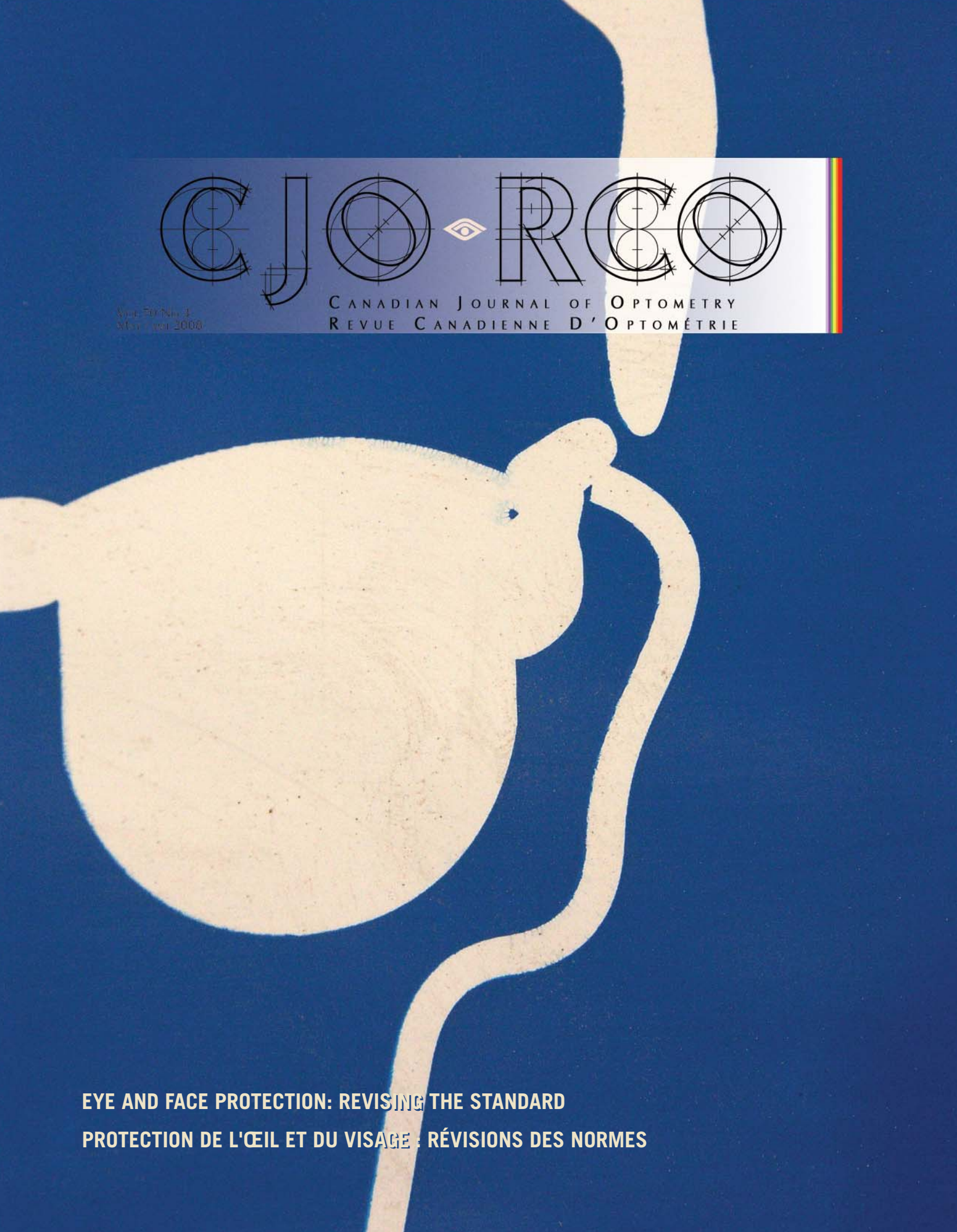
CJO-RCO
Canadian Journal of Optometry
Revue Canadienne d'Optométrie



EYE AND FACE PROTECTION: REVISING THE STANDARD

PROTECTION DE L'ŒIL ET DU VISAGE : RÉVISIONS DES NORMES

Canadian Journal of Optometry
Revue Canadienne D'Optométrie
Vol 70, No 3
May / mai 2008
(Date of issue: May 2008)
(Date de parution: mai 2008)
ISSN 0045-5075

The Canadian Journal of Optometry is the official publication of the Canadian Association of Optometrists (CAO) /
La Revue canadienne d'optométrie est la publication officielle de l'Association canadienne des optométristes (ACO):
234 Argyle Avenue, Ottawa, ON, K2P 1B9. Phone 613 235-7924 / 888 263-4676, fax 613 235-2025, e-mail info@opto.ca, website www.opto.ca.
Publications Mail Registration No. 558206 / Envoi de publication - Enregistrement no. 558206.
The *Canadian Journal of Optometry / La Revue canadienne d'optométrie* (USPS#0009-364) is published six times per year at CDN$55, and CDN$65 for subsriptions outside of Canada. Address changes should be sent to CAO, 234 Argyle Avenue, Ottawa, ON K2P 1B9.

President's Podium • Mot du président

Guest Article • Article Invité

Practice Management • Pratique et gestion

Articles • Articles

Uniform requirements for manuscripts: login to the member site at *www.opto.ca* or contact CAO.
Exigences uniformes pour les manuscrits: voir sur le site des membres à *www.opto.ca* ou contactez l'ACO.

Cover: Doug Dean, Director of Vision Care Plans at the Canadian Association of Optometrists, provides an update on revisions to the CSA Eye and Face Protection Standard Z94.3 in this issue of the CJO (see page 75).

Couverture: Doug Dean, Directeur de Régime professionnel de la vision à L'Association canadienne des optométristes, explique les récentes modifications de la norme Z94.3 de la CSA (voyez à la page 76).

Commitment

Engagement

Len Koltun, OD
President CAO /
président de l'ACO

" Communication is the Key.
La communication est la clé! "

Time brings change, and change brings one constant – our commitment to excellence in patient care. As individual optometrists we express this commitment to our patients, approximately 50,000 times a day across Canada every day in our grass roots local practices. It is through this disciplined commitment to excellence that optometry has evolved during the past 100 years and established a solid foundation of eye health care that delivers value, integrity and superior performance to our patients:

- We deliver *value* by providing high quality service at reasonable cost through individual practitioners.
- We ensure excellence by adhering to the highest standards of competence through University based Doctor of Optometry programs and a commitment to quality entrance requirements administered by the Canadian Examiners in Optometry's
- We exhibit integrity and responsibility through compliance to regulation governed by provincial optometric regulators.
- Our service *performance* is measured by patient satisfaction and trust. Our practice growth, economic success and recognition by governments and health care providers is proof of continuous improvement. And, it is a reasonable conclusion that demand for our services will grow.

These are the cornerstones of our being; what sets us apart; and what becomes the foundation of our commitment for the future - dedicating ourselves to improving the quality of people's lives in Canada and around the world

We cannot predict the future of eye care except to say it will be interesting and challenging. The current environment of rapid transformation creates opportunities, which will require sound policies and commitment to productivity and growth. Many opportunities are defined by market conditions, which we cannot control, but by combining our strong foundations of decency, integrity, dedication, discipline and patient focus with collaboration and communication ('the Key!'), our future potential increases tremendously.

The pace of change is speeding up. Will our commitment to excellence remain constant? It must!! Everyone wants a better world. Delivering on commitments is important in our culture. At the National level, CAO remains committed to its strategic plan. This includes a new diabetic initiative which was identified as a priority at the 2008 Optometric Leaders' Forum. Will you commit to clinical excellence, 'association',

PRESIDENT'S PODIUM
MOT DU PRÉSIDENT

teamwork and communication?

Optometry is commitment, a commitment to collegial excellence, and to a better future for our patients and our profession. This commitment must come from 'within', individually, because ethics and integrity cannot be mandated by any CAO directive or policy. I believe we are well on the way to becoming the profession we want to be and our success will surely continue only if we all remain focused, engaged and committed to our values, ethics and desire to make optometry the 'go to' eye care profession.

Thank you for accepting this commitment and living optometry's challenge and dream.

Avec le temps vient le changement, et le changement ramène une constante – notre engagement à l'excellence dans le soin des patients. Individuellement, nous exprimons cet engagement envers nos patients environ 50 000 fois par jour au Canada, chacun dans son cabinet bien enraciné dans la collectivité. Cet engagement sans relâche à l'excellence a fait évoluer l'optométrie pendant les 100 dernières années et a établi de solides fondations qui offrent valeur, intégrité et rendement supérieur à nos patients :

- Nous offrons de la *valeur* grâce à un service de très grande qualité fourni à prix raisonnable par nos praticiens.
- Nous garantissons l'excellence en adoptant les normes de compétence les plus élevées grâce aux programmes universitaires de doctorat en optométrie et aux examens d'adhésion de qualité des Examinateurs canadiens en optométrie.
- Nous faisons montre d'intégrité et de responsabilité en nous conformant aux règlements des organismes réglementaires provinciaux en optométrie.
- Le *rendement* de nos services se mesure par la satisfaction et la confiance des patients. La croissance, le succès économique et la reconnaissance de notre pratique par le gouvernement et les fournisseurs de soins de santé sont une preuve de notre amélioration continue. Il est raisonnable de conclure que la demande pour nos services ira en augmentant.

Voilà donc les pierres d'angle de ce que nous sommes, ce qui nous différencie et la base de notre engagement pour l'avenir – notre détermination à améliorer la qualité de la vie des personnes au Canada et partout dans le monde.

Nous ne pouvons prédire l'avenir des soins oculo-visuels, mais nous savons qu'il sera plein de défis et intéressant. L'environnement actuel de transformations rapides crée des opportunités qui nécessiteront des politiques valables et un engagement solide à la productivité et à la croissance.

Beaucoup d'opportunités sont définies par les conditions du marché, qui sont hors de notre portée, mais si nous combinons la collaboration et la communication (« la clé! ») à nos bases solides que sont la décence, l'intégrité, le dévouement, la détermination et une orientation axée sur les patients, notre potentiel futur s'accroît énormément.

Le rythme du changement s'accélère. Est-ce que notre engagement à l'excellence demeurera constant? Il le faut!! Chacun veut un monde meilleur. Le respect des engagements est une dimension importante de notre culture. À l'échelon national, l'ACO est déterminée à poursuivre son plan stratégique. Cela inclut une nouvelle initiative sur le diabète qui a été définie comme une priorité au Forum des dirigeants optométriques de 2008. Vous engagerez-vous dans la ligne de l'excellence clinique, de « l'association », du travail d'équipe et de la communication?

L'optométrie est un engagement, un engagement vers l'excellence collégiale et vers un avenir meilleur pour nos patients et notre profession. Cet engagement doit surgir de l'intérieur de chacun de nous, car aucune directive ni politique de l'ACO ne peut obliger à l'éthique et à l'intégrité.

Je crois que notre profession devient de plus en plus ce que nous souhaitons qu'elle devienne, et notre réussite se poursuivra certainement à la condition que nous gardions le cap, déterminés et engagés envers nos valeurs, notre éthique et notre désir de faire de l'optométrie la profession « de choix » des soins oculo-visuels!

Merci d'accepter cet engagement et de vivre au jour le jour le défi et le rêve de l'optométrie.

Eye and Face Protection: Revising the Standard

Protection de l'œil et du visage: Révisions des normes

Doug Dean
Director, Vision Care Plans
Canadian Association of Optometrists / Directeur, Régime professionnel de la vision, L'Association canadienne des optométristes.

Apart from a cup of Tim's, there are few more uniquely Canadian symbols than the trademark of the Canadian Standards Association.

Since 1919, the CSA has published standards that affect the safety and design of a wide range of products and services. From toasters to work boots, the stamp of the CSA is likely found in every home and business in the country.

CSA standards are often cited in Federal, Provincial and Municipal statutes, but adoption of the standards varies by jurisdiction.

CSA standards are developed with the principles of consensus by working committees comprising of a balanced mix of experts from a variety of stakeholder groups, including Industry, Government and Consumers.

CAO is pleased to participate in the Technical Committee on Eye and Face Protection Standard Z94.3.

The committee, whose Vice Chair is the University of Waterloo's Dr. Ralph Chou, is charged with developing the minimum standards for protective eyewear.

CSA Z94.3-07 has recently been published containing the following changes, amongst others, which will be of particular interest to anyone who dispenses or manufactures Class 1 prescription safety glasses.

- Side protection must now be permanently attached to the frame or be integral to the frame design. Previous editions stated that side shields should be present, but did not specify that they be permanently attached.
- The standard has added optional criteria for protective sunglasses for outside workers.
- The standard has clarified the testing procedures for prescription eyewear.
- Minimum thickness requirements for various ophthalmic lens materials have also been revised,
  - Using the results of recent studies, this edition recognizes that lenses made of a certain material at a certain thickness will always pass the impact test requirements.
  - These requirements determine both the high impact resistance of the lens as well as the lens retention by prescription frames.
  - Polycarbonate material may be used with a minimum thickness of 2 mm. The lens can be treated with any combination of tints, scratch resistant or anti-reflective coatings and still meet the impact criteria. The minimum thickness requirement also applies to photochromic or polarized polycarbonate lenses.
  - Trivex™ material meets the impact standard using a minimum thickness of 2.5mm, with the same combination of coatings or treatments as polycarbonate.

GUEST EDITORIAL
ÉDITORIAL INVITÉ

- Plastic CR-39 lenses may be used with a minimum thickness of 3.mm. Scratch coated, tinted, photochromic or polarized CR-39 lenses meet the standard.
- However, the addition of an Anti-Reflective coating to the lens causes the CR-39 to fail the high impact test at any thickness. This revision will arguably have the greatest impact (no pun intended), for end users of prescription safety eyewear.

As an accompaniment to the technical standard, a sub-committee also prepares and publishes an informative user guide. This document contains tips on the selection and care of prescription safety eyewear.

As with all standards, Z.94.3 requires a constant revision cycle in order to reflect the impact of new products and conditions. The Eye and Face Protection Technical Committee continues to explore the potential development of relevant policies for inclusion in the standard, including eye protection for Laser applications and requirements for protection against Electrical Arc Flash.

CSA continues to work towards the completion of a product and lab certification process, with the goal of one day having a "CSA Certified" pair of prescription safety glasses.

Mise à part la tasse de café du Tim, il y a quelques symboles typiquement canadiens, dont celui de l'Association canadienne de normalisation.

Depuis 1919, la CSA publie des normes qui touchent la sécurité et la conception d'une vaste gamme de produits et services. Des grille-pain aux bottes de travail, le logo de la CSA se trouve vraisemblablement dans toutes les maisons et entreprises du pays.

Les normes de la CSA sont élaborées grâce au consensus de comités de travail formés d'un ensemble équilibré de spécialistes provenant d'une diversité de groupes d'intervenants, dont l'industrie, le gouvernement et les consommateurs.

Les normes de la CSA sont souvent citées dans des lois fédérales, provinciales et municipales, mais l'adoption des normes varie d'un secteur de compétence à l'autre.

L'ACO est heureuse de participer au comité technique sur les normes de protection oculaire et faciale Z94.3.

Le Dr Ralph Chou de l'Université de Waterloo est vice-président du comité chargé d'élaborer les normes minimales des verres de protection oculaire.

La norme Z94.3-07 de la CSA a récemment été publiée et elle comporte, entre autres, les modifications suivantes qui intéresseront particulièrement quiconque fournit ou fabrique des lunettes de sécurité d'ordonnance de classe 1.

- Les écrans latéraux doivent être fixés en permanence à la monture ou faire partie intégrante de la monture elle-même. Les normes antérieures stipulaient la présence d'écrans latéraux, mais sans spécifier s'ils devaient être fixés en permanence.
- Les normes contiennent des critères facultatifs qui s'appliquent aux lunettes de soleil de protection des travailleurs à l'extérieur.
- La norme a également précisé les procédures d'essai des verres d'ordonnance.
- On a aussi revu les exigences concernant l'épaisseur minimale de diverses lentilles ophtalmiques.
- À partir des résultats d'études récentes, la norme actuelle reconnaît que des lentilles fabriquées d'un

certain matériau et d'une certaine épaisseur répondront toujours aux critères de l'épreuve de résistance aux chocs.

- Ces critères déterminent la résistance maximale aux chocs de la lentille de même que la rétention des lentilles dans les montures d'ordonnance.
- On peut utiliser du polycarbonate d'une épaisseur minimale de 2 mm. Les lentilles peuvent être traitées par n'importe quelle combinaison de teintes, de couches anti-éraflure ou antireflet et répondre quand même à tous les critères de résistance aux chocs. L'épaisseur minimale exigée s'applique aussi aux lentilles photochromiques ou polarisées en polycarbonate.
- Le Trivex™ répond à la norme de résistance aux chocs à une épaisseur minimale de 2,5 mm, avec la même combinaison de couches ou traitements que pour le polycarbonate.
- On peut utiliser les lentilles CR-39 en plastique d'une épaisseur minimale de 3 mm. Les lentilles anti-éraflure, teintées, photochromiques ou polarisées CR-39 répondent à la norme.
- Toutefois, l'ajout d'une couche antireflet aux lentilles CR-39 les fait échouer l'épreuve de forte résistance aux chocs, quelle que soit l'épaisseur. Cette révision aura une incidence très grande sur les utilisateurs finals de dispositifs oculaires de sécurité d'ordonnance.

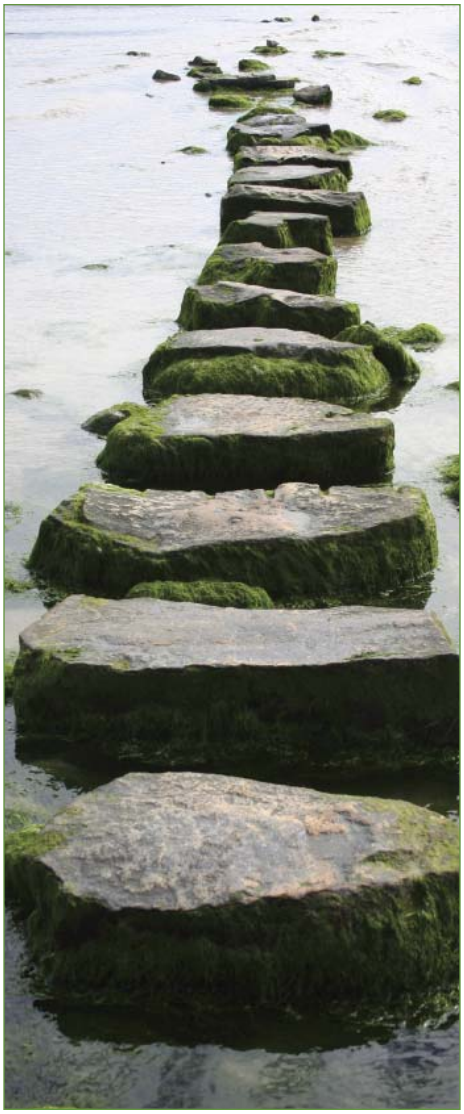
Un sous-comité prépare et publie un guide d'utilisation instructif qui s'ajoute à la norme technique. Ce document contient des suggestions sur le choix et l'entretien de dispositifs oculaires de sécurité d'ordonnance.

Comme pour toutes les normes, la Z.94.3 doit être continuellement revue afin de refléter l'incidence de conditions et de produits nouveaux. Le comité technique pour la protection oculaire et faciale continue d'étudier des politiques susceptibles d'être incluses dans la norme, ce qui comprend la protection oculaire face aux applications du laser, et les critères de protection contre le flash d'arc électrique.

La CSA continue de travailler à un processus d'agrément de produit et de laboratoire, afin d'en arriver à une paire de lunettes de protection d'ordonnance «*homologuée CSA*».

Take Your Practice to the Next Level - Part 1

Alphonse Carew
BSc, OD, MBA



In his book "*The E-Myth Revisited*", author Michael Gerber provides compelling arguments as to why businesses fail or never live up to their full potential. As I read it, I felt there were numerous parallels in the optometric practice. Although practices rarely actually fail to the point where they fall into bankruptcy, many do not live up to their earnings potential and owners find themselves struggling with the day-to-day operations. They hit a wall and practice life is not enjoyable anymore.

The typical cycle sees the optometrist starting out excited about putting into practice what he has learned in university, some terror as he starts, then over the years he moves into exhaustion and burn-out as he gets busier and tries to do all tasks. Then finally despair when he realizes his dream practice has turned into a job. However, it doesn't have to be that way.

Gerber's book suggests that there are three aspects to any business owner. There is the entrepreneur who is the idea person, the visionary. He provides the vision for what his dream practice should look like. There is the manager who will put processes in place to keep things running smoothly. As a manager he is pragmatic and provides the order necessary to get things done effectively and efficiently. Finally, there is the technician who is the doer and gets things done anyway he can, he just wants to get the job done.

These three personalities are necessary for a business to be successful. The entrepreneur to provide the overlying mission of the practice, forward thinking and reacting to competitive forces to provide the best practice for the patients. The manager who provides the rules so things get done, on time and in the right manner, dealing with staffing issues, schedules, banking matters, etc. The technician to actually do the work of seeing patients, taking care of their needs.

The problem arises when these three aspects of the practice owner are in conflict, which is often. The dreamer entrepreneur can't be bothered with the pragmatic management concerns, nor the day-to-day handling of patients that the technician has to do. The manager likes to put things in specific boxes, which runs contrary to the visionary entrepreneur and only frustrates the technician. The technician has no interest in the dreamer's ideas or the manager's rules, he just wants to get things done.

The practice actually needs the three of these characteristics, usually at different times and for different jobs, to be successful. In the typically practice with a solo-practitioner owner, only one of these personality traits are dominant and over time this trait will take over. For most people their dominant trait is the technician. I suspect given the nature of our work and training, optometrists likely have this as their dominant trait in a greater ratio than the general population. As optometrists we understand the technical aspects of our work much more so than the managerial or entrepreneurial roles, and this could be our greatest liability. Over time as the practice gets busier the business of just getting the job done takes centre stage. Thoughts on how to prepare the practice for future growth, and how to best compete in the marketplace are pushed to the side. Management rules and processes that take much time and effort are forgotten as our technician's role concentrate on getting through the day.

As the practice gets even busier the technician optometrist begins to see his day filled with patients to take care of, which is somewhat comforting to our technician trait. However, while this is being addressed other office administration tasks are being left behind. Soon these unattended task show up as staff discontent and practice stagnation. The practice starts to loose its competitive edge as the ideas of the forward thinking entrepreneur are stifled. Financially the practice may still be doing OK, but it is not growing and not living up to its full potential.

In order take your practice to the next level you need to support the manager and entrepreneur traits in you, alternately you can seek advice from, or hire someone for these positions. More on that in the next issue of the Canadian Journal of Optometry.

Ptosis Spectacle

Narendra Kumar
BAMS, DROpt, PGCR
OphthaCare Eye Clinic,
C4F/216 Janakpuri,
New Delhi 110058, India
OptometryToday@gmail.com

The condition of Ptosis is discussed with its classification and management by surgery, scleral contact lenses and ptosis crutch. The method of the making of the ptosis spectacle - using a nylon thread support that is effective, comfortable, and reasonably inconspicuous – is explained.

Ptosis is a drooping of the upper lid, which is usually due to weakness, deficient development or absence of the levator palpebrae superioris muscle. The normal upper lid rests approximately 2 mm below the upper limbus when the eye is looking straight ahead. The lower lid normally rests 1 mm above the lower limbus. The palpebral fissure for adult males is between 7 and 10 mm and for females it is 8 to 12 mm. According to Coles[1], ptosis (bilateral or unilateral) may be (i) congenital when it is present at birth, or (ii) acquired when it develops after birth.

Acquired ptosis may be a) senile or age related, b) a result of oculomotor (third nerve) palsy, c) due to intracranial tumour, or d) a result of trauma, as in intraocular surgery, e.g., after cataract surgery. Pseudoptosis can be simulated in a small globe due to injury or inflammation resulting in an abnormal shape, as in pthisis bulbi.

The patient complains of the cosmetic effect of the drooping of the upper lid, and in more marked cases there may be interference with vision. In congenital cases this interference may be sufficient to cause amblyopia.

Lyle and Cross[2] suggest the following line of treatment. In cases of congenital origin, if the deformity is not of gross degree and there is no interference with vision which might lead to amblyopia, surgical treatment may be postponed until the child attains the age of four or five years; otherwise the operation may be needed even for cosmetic reasons. When the condition is acquired treatment depends upon the cause which must be investigated. In cases of paralysis of the oculomotor nerve, however, the drooping eyelid may serve the useful function of preventing double vision, and if there is useful vision in the eye the possibility of correcting diplopia should be considered before the eyelid is returned to its normal position. Also, surgical correction by fixing the eyelid at a higher level should not be so great that the eye cannot be closed.

DeSouza et al[3] describe an infant having congenital bilateral ptosis and the remarkable ability to lift the eyelid with the hand in order to see! (Figure 1).

But, in cases where surgery is not preferred or indicated and in elderly patients, a prosthetic device such as a ptosis props fixed to the back of the spectacle frame (or ptosis crutch or a ptosis spectacle) is often of great value.

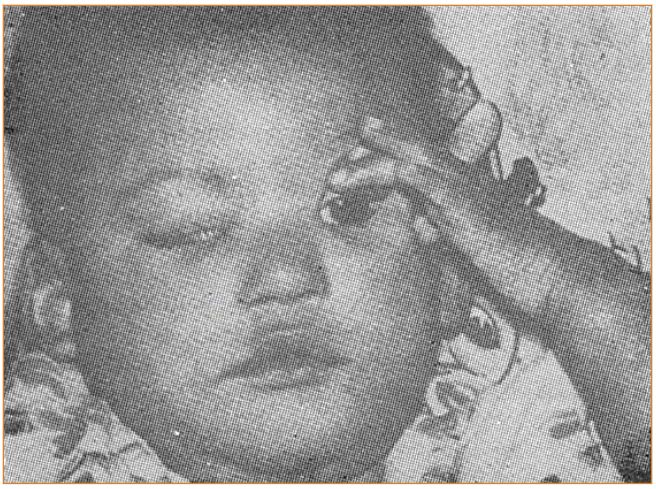


Figure 1: This photograph, of the infant having congenital bilateral ptosis due to Mobius's syndrome, taken at the age of 7 months, illustrates her remarkable ability to lift the eyelid in order to see, a skill that was repeatedly demonstrated from 6 months of age.

Till recently, in India, a small semi-circular piece cut from the periphery of an old gramophone record used to be glued to the inside of the upper portion of a plastic spectacle frame to lift and support the drooping upper lid. But, the device was not cosmetically appealing and was also not comfortable.

Moss[4] reports on the method of relieving ptosis with the use of a scleral contact lens. Either the superior flange of the shell is built up by increasing the mass, which will move the upper lid and improve ptosis, or a shelf is placed across the upper section of the scleral lens to support the upper lid. But this approach results in lack of blinking. Moss[4] also details the making of an improved crutch by utilizing steel orthodontic round wire of spring tempered quality and fixing it to the bridge of a modern plastic spectacle frame to improve cosmesis and give greater movement to the upper lid. The procedure is, however, cumbersome and needs precision.

Let's now consider a comparatively easier method of making a ptosis spectacle by fixing support[5] (made of so-to-say non-conspicuous nylon thread that is sturdy and comfortable, too) to a plastic frame. A hole, slightly smaller than the thickness (diameter) of the support, is drilled at the bridge on the front side of the frame. One end of the support is thinned with a surgical knife or razor blade and the cord (nylon thread) pushed on the inside of the frame. Another hole is drilled at the temple on the inside of the frame out of which the free end of the cord is pulled out. The nasal end of the cord is pressed with a plier so as to flatten it to pre-

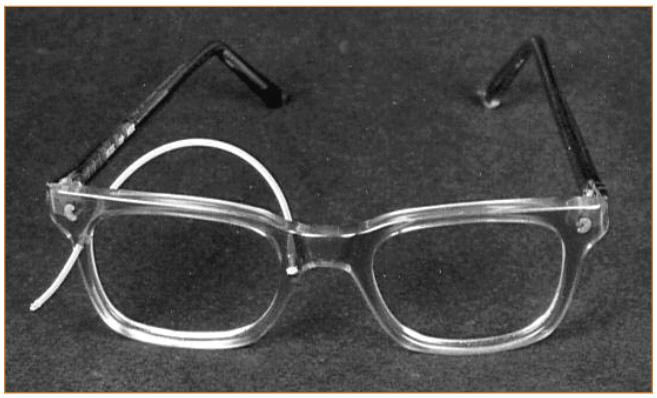


Figure 2: Ptosis spectacle (frame fitted with support)

vent it from coming out of the hole at the bridge. Easy adjustment can be made by pulling the support from the front at the temporal end with a pair of pliers until the required depth is achieved (Figure 2). The support will then fit the contours of the upper lid. Care needs to be taken not to over-correct the drooping upper lid elevation, so as to avoid secondary mechanical effects on ocular surface/adnexa due to the support.

Step-wise revision of the fixing of the ptosis support.[7]

1. Drill two holes with a smaller diameter than the nylon cord through the temporal and nasal ends of the eyewire.
2. Taper the ends of the cord and thread through the holes from the proximal side.
3. With a pair of pliers, pull the cord through frame at the bridge and cut off the cord level with the frame (the fact that the hole is smaller than the cord will make it a secure fit).
4. Fit the frame on the patient and pull the cord through until the support is in the correct position, then cut off surplus cord.

The prosthetic device can correct almost all types of ptosis. The cosmetic improvement is startling, the emotional impact is rewarding, and there may well be the possibility of prolonged functional improvement in the condition because of mechanical stimulation[6].

REFERENCES

1. Coles WH: Ophthalmology – A Diagnostic Text. 1989. Williams & Wilkins, Baltimore, U.S.A.
2. Lyle TK, Cross A G: May & Worth's Manual of Diseases of the Eye. 1959. Bailliere, Tindall and Cox, London, U.K.
3. DeSouza R, Spencer DA, Coe A: Infant's photograph cited in Optometry Today (India), Vol. 18, No. 1, 1992.
4. Moss HL: Prosthesis for blepharoptosis and blepharospasm. J Amer Optom Assoc 1982; 53: 661-667.
5. Ptosis spectacle is made/support is supplied by Optometry Today <kumars@vsnl.com>
6. Walsh G, Rafferty PRM, Lapin J. A simple new method for the construction of a ptosis crutch. Ophthal Physiol Optics 2006; 26(4): 404-407.
7. Personal correspondence (letter dated April 12, 1984) with Mr. Gordon Duff of G.D. Spectacle Wear Ltd., Swansea, Glam., U.K.

Join us in the World Sight Day Challenge, October 9, 2008

Joignez-vous à nous pour le défi de la Journée mondiale de la vue: 9 octobre

The Optometry Giving Sight World Sight Day Challenge (WSDC) raised almost $75,000 from Canadian optometrists, their staff, patients and our corporate partners in October 2007 to help fund sustainable primary eye care projects in the developing world. Doctors took the challenge by donating their eye exam fees on World Sight Day and/or committing to a regular monthly or annual donation.

In addition all participating practices were sent a full kit of materials to promote the WSDC in their practice and in their community.

Here's what some of the participants said:

" Just wanted to let you know how much fun we are having here on World Sight Day! I'm having a great time chatting about our charity and the patients so far have been very generous! " — *Dr Kirsten North, Nepean, ON. Vice President of the CAO.*

" Our patients and staff were very excited about participating in the World Sight Day Challenge! We're looking forward to next year. " — *Dr Dan Lowe, Calgary Alberta. President of the AAO.*

" Our Practice was proud to take the Challenge last year. We had fun while supporting a great cause. " — *Dr Len Koltun, Regina, Saskatchewan. President of the CAO.*

Jane Ebbern
Country Manager,Canada
Tel: (800) 585-8265 ext 4
or (403) 670-2619
Fax: (403) 270 1899
4 Parkdale Crescent NW
Calgary AB T2N 3T8
www.givingsight.org

" I'm a parent as well as an eye health care professional. That's why supporting World Sight Day is such a priority for me. We have to find ways to provide regular eye care for children in countries where no such services have existed before. " — *Dr Dorrie Morrow, Sherwood Park, Alberta. Past President of the CAO.*

" It was great to participate in World Sight Day this year. The staff got enthusiastic about the one-day event and were proud of their accomplishments that day. The press coverage of the event created a very positive buzz in the community and many patients that day were pleased to hear that their examination fees were being contributed to such a great project. As a Doctors Eyecare Network (DEN) member, these contributions are part of DEN's Giving Circle. "
— *Drs Oliver, Martin and Johnson, Wetaskiwin, Alberta.*

The World Sight Day Challenge on October 9, 2008, promises to be even bigger and better. Request information on how you and your practice can be involved by filling in the postage paid card that was included with this CJO. Or you can register your interest on-line at www.givingsight.org or by calling 1-800-585-8265 ext. 4. Find out more about how you can be part of this fun promotion to support the CAO's International Charity of Choice.

Le défi de la Journée mondiale de la vue d'Optometry Giving Sight (*Optométrie-Dons-Vision*) a permis de recueillir presque 75 000 $ auprès d'optométristes canadiens, de leur personnel, de leurs patients et de nos sociétés partenaires en octobre 2007, dans le but de financer l'établissement de soins de la vue primaires durables dans les pays en développement.

Les docteurs ont relevé le défi en donnant les honoraires tirés des examens effectués pendant la Journée mondiale de la vue ou en s'engageant à verser des dons mensuels ou annuels.

Tous les participants ont reçu une trousse complète pour faire la promotion du défi dans leur bureau et leur collectivité.

Lisez les témoignages éloquents de certains participants au défi d'octobre 2007.

« Je voulais juste vous dire combien nous nous sommes amusés ici pendant la Journée mondiale de la vue! J'ai beaucoup de plaisir à parler de notre œuvre de charité et, jusqu'à présent, les patients ont été très généreux! »
— *Dre Kirsten North, Nepean (ON), vice-présidente de l'ACO.*

« Nos patients et notre personnel ont participé avec enthousiasme à la Journée mondiale de la vue! Nous avons hâte à la prochaine! » — *Dr Dan Lowe, Calgary (Alberta), président de l'AAO.*

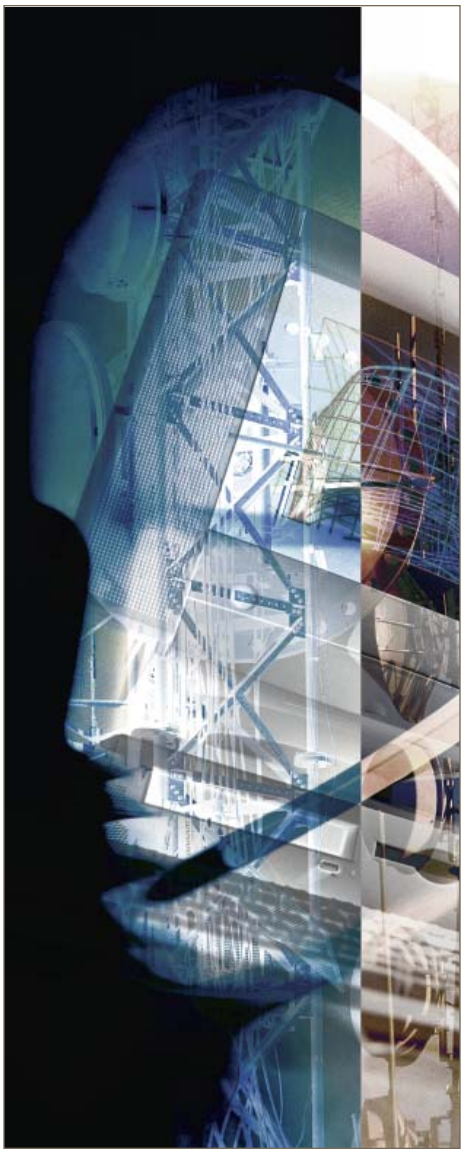
« Notre bureau a relevé le défi avec fierté l'an dernier. Nous nous sommes amusés tout en appuyant une grande cause. » — *Dr Len Koltun, Regina (Saskatchewan), président de l'ACO.*

« Je suis mère en plus d'être professionnelle des soins de la vue. C'est pourquoi il est tellement prioritaire pour moi de relever le défi de la Journée mondiale de la vue. Nous devons trouver des moyens de fournir des soins de la vue régulièrement aux enfants dans les pays où ces services n'ont jamais existé auparavant. »
— *Dre Dorrie Morrow, de Sherwood Park (Alberta), présidente sortante de l'ACO.*

« Ce fut formidable de participer à la Journée mondiale de la vue cette année. Les employés étaient enthousiastes et fiers de leurs accomplissements de cette journée. La couverture par la presse a soulevé des réactions très positives dans la collectivité et beaucoup de patients ce jour-là étaient contents de savoir que les honoraires de leur examen allaient servir à un aussi beau projet. »
— *Drs Oliver, Martin et Johnson, Wetaskiwin (Alberta).*

Le défi de la Journée mondiale de la vue du 9 octobre 2008 promet d'être encore meilleur et plus grand. Obtenez de plus amples renseignements sur la façon d'y participer en remplissant la carte postale pré-affranchie qui accompagne le présent bulletin d'information. Vous pouvez aussi manifester votre intérêt en ligne à *www.givingsight.org* ou en téléphonant au 1-800-585-8265 poste 4. Renseignez-vous sur la façon de prendre part à cette activité de promotion amusante pour appuyer l'organisation caritative internationale de choix de l'ACO.

The Story of Optometry News Network



In the spring of 2006, Dr Hari Amarnath and Dr John Peacock sat down to review the independent consultant's report that they had commissioned to help them analyze the business opportunities and strengths of their Alliston, Ontario optometry clinic. The two doctors, who operate the New Tecumseth Optometry Clinic (NTOC), had recently invested nearly two hundred thousand dollars renovating their main street heritage building and were seeking an outside opinion on ways that they could improve the overall patient experience and at the same time support the business objective of growing the clinic dispensing revenues.

One of the key findings of the report focused on the clinic waiting areas. It stressed the importance of using waiting spaces to educate patients on their eye health options. "It made the point that many patients aren't aware of the latest product advancements that could help improve their quality of life. And that raising patient awareness about their eye health choices will stimulate exam room discussions and help drive dispensary sales" said Dr Peacock.

That report led the two doctors to rethink the role of their waiting areas and to investigate existing waiting room products in the marketplace. Dr Amarnath: "Before starting up NTOC, John and I were practicing at two of the more progressive clinics in Canada. We were already familiar with existing LCD dis-

ARTICLE

play products for optometrists, but when it came to the waiting room, they were either too narrowly focused on eye conditions, or they suffered from stale content that hadn't been updated in months. We liked the idea of educating patients on eye health, but we also wanted something entertaining and visually appealing that would keep people's attention."

After an exhaustive product search, the two doctors came away with two key learnings: one, that the product they envisioned did not currently exist in the market place; and two, if they wanted such a product in their clinic, they would have to build it themselves. So after months of planning and development the two doctors announced the launch of Optometry News Network.

A new marketing channel

Their new waiting room display had an immediate positive impact. So much so that it prompted the doctors to start talking about making ONN available to their fellow optometrists. They had a unique product that they believed could help the independent OD enhance their practice.

Dr Amarnath feels that one of the key benefits of ONN is how the product solves what can be a delicate business problem. "As doctors we need to be careful how we present to patients the full range of product and services available at our clinic. We don't want to come across like we're selling anything, but at the same time we know that if we're not educating our patients on the value we can offer them, then there's a good chance they will leave our clinic to make an uninformed buying decision."

"Most large corporate retailers don't provide anywhere close to the level of post-purchase service that we offer, and many patients don't know the true apples-to-apples value comparison. Now, ONN lets us communicate directly to our patients and there's no worry about it coming across as a sales pitch."

With the ever-growing threat posed by large corporate entrants in the optometric retail market, Dr Peacock feels ONN can be a powerful tool for the independent optometrists. "The big box stores and corporate chains have the resources to broadcast their marketing campaigns to the general public over traditional media

"One area for improvement that stood out to us in the report was the opportunity to promote the array of products and services we offer within our own reception and waiting areas. You only have the patient in your office for a short amount of time, and our selection of *Maclean's* and *Time* magazines weren't doing anything to help us meet our business objectives."

— Dr. John Peacock

channels. However, those broadcast commercials typically only reach a tiny fraction of the overall target market. In contrast, ONN is a 'narrow-casting' marketing tool that speaks directly to patients faced with imminent optometric buying decisions."

Doctor Peacock says ONN works complementary with existing external marketing efforts. Where external advertising helps to grow the clinic patient list, ONN is focused on delivering business benefit in the form of revenue per patient. "The value that ONN delivers is pretty straightforward – it highlights the specific products and services of that very clinic to a captive audience that is already sitting there because they have an eye care need."

The basic ONN package is comprised of a media player and a high resolution 32" LCD display screen that can be wall or ceiling mounted. The ONN channel

itself consists of headline news as well as entertainment and sports news provided by Canadian Press, while local weather forecasts are from *The Weather Network*. Clinic specific information and promotional material can be selected from a catalogue of pre-designed messages or the messaging can be customized.

The two doctors are happy with how warmly ONN has been received to date and are looking optimistically to the future, "Ideally, we'd like to see this become a staple product in the Canadian independent optometry clinic. Clearly we think there's an obvious and very real value proposition with ONN, and it feels good to be able to offer a service that strengthens the position of the independent optometrist in today's ever increasingly competitive environment," says Dr Peacock.

Optometry News Network is now available to CAO members for $149 per month for a single screen subscription. For additional pricing and product demonstration, you can find ONN on the web at www.clinicalnetworks.ca.

CNIB-CGCRC Award
Clinical Glaucoma Research Opportunity

CNIB and the Canadian Glaucoma Clinical Research Council (CGCRC) are pleased to announce a new partnership for funding of clinical glaucoma research in Canada. **CNIB–CGCRC** awards will total $225,000 over a three year period. Scientific peer review of research proposals will continue to be conducted independently by CGCRC while administration of awards will be conducted by CNIB.

There are two application deadlines for the **CNIB-CGCRC Award**. They are October 31 and May 15 of each year. The maximum amount of each award is $25,000.

Registrants can apply online at the CGCRC website, http://www.cgcrc.ca/sign_in.cfm. For further application information, please contact Shampa Bose, CNIB, at 416-486-2500, ext. 7622, or email shampa.bose@cnib.ca.

Funding of the **CNIB-CGCRC Award** is via an unrestricted grant from Alcon Canada Inc.

The End of the History of Optometry and the Beginning of a New One

In Canada, the first legal use of the term "Optometry" was in 1909.

Santos Tseng
OD, UW Class of 2004
PhD Student in
Vision Science
Clinical Optometrist

Oh, I'm not talking about the actual history. Beginning this September, OPTOM 100, the autobiographical course for our very own profession, will no longer be a part of the optometric curriculum at the University of Waterloo. No, the aptly-named course is apparently slated for oblivion, forever stricken from the annals of Optometric education.

But how? Isn't that our history? Why would anyone think of doing away with that? Before any of us collectively rise in arms against this apparent injustice, an understanding of the reasoning behind this development might be in order.

The optometric landscape in Ontario is changing. The use of therapeutic pharmaceutical agents, virtually inconceivable even just ten years ago, is at the proverbial doorstep for the province's optometrists. With the change in scope comes a change in education. Given the need to include courses such as Immunology (OPTOM 134), Histology (OPTOM 108) and Human Gross Anatomy (OPTOM 124), there is apparently no room for the old course in the new curriculum. History of Optometry will thus be banished to history this upcoming fall. Gone, they say, with the wind.

Hmm. So, what will this change mean to those of us in practice? On the surface, it may

not seem like a lot. A quick survey of my Class of 2004 peers produced the following:

"*It's about time!*"

"*Good riddance!*"

"*It's not like we used any of it anyways!*"

Indeed, the popular belief is that the elimination of History of Optometry is of little clinical consequence. Change, however, never occurs in a vacuum. Is the termination of OPTOM 100, therefore, a bellwether sign of change to come?

It has been suggested that as long as optometry continues to become more medically oriented, we risk losing elements of eye care that have defined our success in the past. Optometric graduates from yesteryear claim we don't dispense spectacles as well as we used to. We probably don't fit rigid lenses as well as we used to. With the binocular vision clinic at the School relegated to a few rooms on the second floor, we certainly don't do BV as well as we used to.

One could even argue that our bread-and-butter element, refraction, is a beleaguered entity these days. A quick perusal of the association website of our spectacle-dispensing brethren will show a handful of MPPs, and even a former Minister of Education endorsing the optician right to refract. Indeed, if change is what we are after, there are groups who are only too willing to give it to us.

Should we therefore be afraid of change? No. Change, they say, is a good thing. But before we embrace it, we must first understand it. But in order to understand it, we must first understand ourselves. Are we meeting the needs of our patients? Do we inspire confidence in them? What are we doing right? What can we be doing better? Is the current model of optometry sufficient, and if not, how can we improve? Does the evidence suggest a need for us to become more medically oriented?

Like an organism, our profession will evolve. But before we do, we should be sure of what it is we are evolving into, to ensure it is truly progress and not something else. Looking forward, each one of us optometrists will continue to make up and define this profession. We will all be oarsmen paddling the same ship. It is imperative that we also decide where it is we want it to go.