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Last year RANZCO underwent accreditation with the Australian Medical Council (AMC). Accreditation is the process that ensures our education and training meet national standards for medical colleges.

These standards define the knowledge, skills and professional attributes that are expected in specialist training. The AMC is the external accreditation agency for the purpose of the Medical Board of Australia. AMC accreditation is a peer review process with an expert assessment team that ensures the quality of education, training and assessment of the medical profession meet the national standards.

Overall the report was good. The AMC team reported an excellent standard of clinical teaching. They felt we have a fair and transparent examination system and our processes produce a uniformly high standard of graduate ophthalmologists. They did, however, raise some concerns over workforce distribution.

The AMC team suggested registrars as well as a lay person be involved in selection and governance. There were also some recommendations regarding the curriculum review, including the introduction of new educational theories such as spiral learning.

Overall there were 54 recommendations that need to be addressed and resolved. In summary, the AMC suggested three years’ accreditation pending an acceptable response to these issues. Last time we went through the full process of accreditation we were given a
10-year accreditation, which is five years of full accreditation and five further years after a self-reported assessment in 2011. However, since then the climate has changed significantly in terms of college accreditation.

The current climate facing colleges has to some extent been shaped by the highlighting of sexual harassment, bullying and discrimination by the media and the Royal Australasian College of Surgeons’ response with their external advisory group. Numerous changes to the AMC guidelines have been recommended and this has flowed onto changes in the standards for accreditation. The AMC has also received complaints from various sources and they have responded to this with extensive changes to the standards. RANZCO was the first college to be assessed under these new standards. Of course, ultimate responsibility for the reduced level of accreditation lies with the RANZCO Board, the CEO and the Education Team, who are jointly exploring a number of changes that have been and will need to be implemented.

RANZCO’s response has been comprehensive. Our new Censor-in-Chief, Dr Justin Mora, and our new Head of Education, Ruth Ferraro, are hard at work rewriting, modernising and formatting the policies criticised. Most of the legal work will be completed early this year and this has been a considerable expense.

This year we are planning a travelling road show to all training posts to help improve our education system and make sure supervisors and trainees understand the new training framework. We will arrange educational seminars on performance management, having difficult conversations and other pertinent topics. All the recommendations from the AMC for 2017 will be met and exceeded as these represent the minimum action RANZCO needs to undertake.

There are a number of aspects of our training system that need to be changed to fit in with society’s expectations of a fair and safe workplace whilst still maintaining the acknowledged excellence of our technical competence. I regard this as an opportunity to better support our Fellows involved in education, and to make our already good system even better.

A/Prof Mark Daniell
President, RANZCO
When the winds of change blow – some people build walls, others build windmills. (Chinese proverb)

The RANZCO 2017-2020 Strategic Plan prioritises the development of the Vocational Training Program (VTP) as encapsulated in this statement:

*Facilitate the highest quality practice of Ophthalmology through evidence based education, training and accreditation.*

The timing of the recent Australian Medical Council (AMC) review and the recommendations that arose from it are extremely helpful as a stimulus to drive necessary improvements to the VTP.

We have a two-part change agenda – a sprint and a marathon. With the Scientific Congress of 2016 behind us, the professional RANZCO staff have been busy preparing the necessary resources to deliver the 2017 list of AMC recommendations in time for the September review – this is the sprint. We also have our eye on our future direction, which will require significant consultation.
and consideration to produce the best outcome – this is the marathon.

As Catherine Livingstone AO1 said, “regulation fixes yesterday’s problems”. While we must meet the regulator’s requirements (for yesterday’s problems) we want to go beyond mere compliance and take the opportunity to improve all our processes. To apply the proverb – we want to be building windmills.

The best way to manage change is to bring as many stakeholders as possible along on the journey. With this in mind we are preparing concept papers for consideration by the RANZCO Fellows who represent you on the Board, the Council and the Qualification and Education Committee.

Our preparation for change has been informed by the excellent work of A/Prof Ivan Goldberg and his group of 50 contributors to the previous major VTP review, the 1996 Lancemore Hill Curriculum Project. We will use the findings of the 2011 thesis by A/Prof Deborah Colville and the more recent achievements of the curriculum review team headed by Prof Paul Mitchell. We are also fortunate to have the expertise of Dr Catherine Green as Curriculum Committee Chair.

Our change agenda or statement of works for 2017 is essentially the AMC recommendations list as set out below:

<table>
<thead>
<tr>
<th>ITEM No.</th>
<th>AMC RECOMMENDATIONS</th>
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<tbody>
<tr>
<td>6</td>
<td>Develop more formal and effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education. (Standard 1.6.4)</td>
</tr>
<tr>
<td>16</td>
<td>Address the negative attitudes towards part-time training and provide clear information to trainees who wish to pursue this option. (Standard 3.4.3)</td>
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<td>25</td>
<td>In relation to the End of Term assessment, ensure that multiple sources of documented feedback are considered in the assessment and that the sources and content of feedback are known to the trainee. The College must ensure that this transparency is also adopted by all committees that deal with trainee performance and progression. (Standard 5.2.1 and 5.3.1)</td>
</tr>
<tr>
<td>27</td>
<td>Implement a process of review of borderline candidates in examinations and work-based assessments before pass, remediation or fail determinations are made. (Standard 5.2.3)</td>
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<tr>
<td>29</td>
<td>Revise the remediation policy to allow a trainee to repeat a ‘term’ with a different educational supervisor at the request of the trainee, supervisor or Director of Training. (Standard 5.3.3)</td>
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<tr>
<td>33</td>
<td>Implement regular and safe processes for trainees to provide feedback about program delivery and program development. (Standard 6.1.3)</td>
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<td>37</td>
<td>Publish the weightings for the various components used by each of the training networks for selection onto the training program. (Standard 7.1.1 and 7.1.2)</td>
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<td>40</td>
<td>Review and change processes for the appointment of trainees to the Trainee Representative Group to ensure true representation and implement reforms that strengthen representation of trainees within the College. (Standard 7.2.1)</td>
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<tr>
<td>41</td>
<td>Institute a framework to promote the wellbeing of trainees and to deal specifically with issues of discrimination, bullying and sexual harassment in association with other key stakeholders. (Standard 7.4)</td>
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<td>46</td>
<td>Develop and implement a system to monitor training sites to ensure adequate follow-up of any recommendations between accreditation cycles. (Standard 8.2.1)</td>
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<td>51</td>
<td>Develop and implement a formal process for fellows who request or require retraining. (Standard 9.2.1)</td>
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<tr>
<td>52</td>
<td>Develop and implement a formal process for fellows who require remediation. (Standard 9.3.1)</td>
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As I foreshadowed in the previous update of Eye2Eye, we have been reviewing our recruitment and selection for the VTP and this has also been a focus since the Congress. We are undertaking an in-depth review of our selection criteria and our interview processes to try to ensure that we are recruiting not just the best candidates but also a diverse enough group to fulfil the needs of our community.

Coherence and accord between the commitment statement of the Diversity and Inclusion Committee and the selection criteria of trainees must be achieved:

RANZCO is committed to fostering a culture of inclusiveness where all individuals are respected, are treated fairly, feel like they belong and can thrive.
We need to examine our systems and processes to ensure no inherent biases prevent application to and successful progression through the VTP. One feature of this is the Policy on Interrupted and Part Time Training.

The College as a whole is trying to improve community representation, including on the education committees, and we expect this will help us to deliver a high quality contemporary medical education which will serve all parts of our society.

In conclusion, the professional staff at RANZCO have prepared the resources and are on track to deliver the outcomes required by the AMC by September this year. But we are also cognisant of the need to look beyond this date and make the fundamental changes needed to move the training program ahead over the long term.

For this review to be successful we need to build a great team of contributors. If you would like to hear more about our work ahead or make a comment or contribution, please contact Ruth Ferraro, RANZCO’s Deputy CEO and Head of Education, at rferraro@ranzco.edu or Craig Dowling, General Manager Trainees and Examinations, at cdowling@ranzco.edu.

**Dr Justin Mora**

*Censor-in-Chief, RANZCO*

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1. Catherine Livingstone, President of the Business Council of Australia, National Press Club Q and A session (29 April 2015)
In the past two issues of Eye2Eye, RANZCO Honorary Fellow Ms Margaret Dunn provided an extensive overview of the College’s Censors-in-Chief over the years. In the final article of this three-part series we feature A/Prof Ivan Goldberg, Dr Peter O’Connor, Dr David Kaufman and Dr Mark Renehan.

A/Prof Ivan Goldberg

A/Prof Ivan Goldberg succeeded Dr O’Day as Censor-in-Chief in 1993 and continued in this role for six years. In the initial years of A/Prof Goldberg’s role as Censor-in-Chief an increasingly complex external world was developing, brought about by new scientific developments, new surgical procedures, changing patient and community expectations, and changing government policies and regulations.

A/Prof Goldberg appreciated that the training program had to equip trainees with knowledge and skills to work successfully in the changing professional environment. Therefore, every aspect of the Vocational Training Program (VTP) was progressively reviewed by the Qualification and Education Committee (QEC) to meet the challenges posed by the changes.

Ivan Goldberg was born in Johannesburg, South Africa in 1947. He received his early education in Johannesburg from 1954 to 1961 before attending Hendon Grammar School in London from 1961 to 1962 where he was the Senior School Swimming Champion. After migrating to Sydney he attended Vaucluse High School where he was First Speaker of the Debating Team, School Prefect in 1963 and School Captain in 1964. In 1964 he won a scholarship at the Sydney University Summer Science School and was also awarded the Rotary Citizenship Award for NSW.

A/Prof Goldberg gained his MBBS at Sydney University in 1971 and worked at the Sydney Hospital from 1971 to 1973 before taking up ophthalmology registrar positions at the University of New South Wales and the Prince of Wales and associated hospitals from 1973 to 1977. During A/Prof Goldberg’s training program at the Prince of Wales Hospital, Professor Fred Hollows, Dr John Sarks and Dr Ivan Cher became his mentors. He was awarded FRACS and MACO in 1977 and continued with further study in glaucoma at Washington University School of Medicine, St Louis, Missouri from 1978 to 1980.

On returning to Sydney in 1980, Ivan pursued clinical and academic activities, especially in glaucoma, and provided editorial support for the College journal. Having been initially involved on the Part I Board of Examiners as a physiology examiner, he took over as Chair of the Board and stepped down from that position after six years to take up the position of Censor-in-Chief in 1993. Many innovations were introduced and changes made to the VTP during his time as Censor-in-Chief.

In 1996, under A/Prof Goldberg’s leadership, the QEC launched a review of the curriculum to define the knowledge, skills and attitudes required by an ophthalmologist and to delineate what needed to be taught and assessed: workshops had been held in 1996 and 1997 to review the curriculum, and seven key roles and associated competencies were identified. Selection, supervision, educational strategies, assessments and evaluation were also addressed. These workshops provided a framework to develop new approaches to training. In 1998 a formal subcommittee was established to drive the process forward to achieve a revised training program to mark the start of the new century. The seven key roles with their associated competencies underpinned every aspect of developing the training program.

In 1997 agreement was reached around Australia to participate in the National Ophthalmic Matching Program (NOMP). To assist supervisors in delivering constructive criticism to trainees when required, a workshop on Training the Trainer was held. In 1998 it became clear that some trainees had little idea of the role of the College and saw it as incidental to the acquisition of clinical training delivered through the hospital training posts.

A/Prof Goldberg contributed an immense amount of time and effort to the advancement of the College’s education review as well as contributing to community organisations. He recognised the generous input by the many Fellows of the College to the numerous Qualification and Education activities. He deemed that support for research and for teaching eye care skills to non-ophthalmologists, such as general practitioners, was implicit to enhance the high standards. He was presented with the Distinguished Service Award by the Asia-Pacific Academy of Ophthalmology (APAO) and also an Achievement Award by the American Academy of Ophthalmology (AAO), both in 2007. From 2006–2008, A/Prof Goldberg was President of the World Glaucoma Association and was the Congress President for the APAO Congress held in Sydney in 2011. He was founding President of the South East Asia Glaucoma Interest Group from 1997–2007 and was elected as founding President of the Asia Pacific Glaucoma Society in 2012. In 2011 he was awarded Member of the Order of Australia for services to medicine, particularly in the field of ophthalmology through national glaucoma support organisations, and to education. In the same year he assumed the Presidency of Glaucoma Australia, having been Vice President from 2000 and a Councillor from 1988.

In May 1999 the Australian Medical Council (AMC) invited all Australian medical colleges to comment on their Discussion Paper on the Accreditation and Recognition of Vocational and Specialist Education. The paper contained the AMC’s response to a request from Dr Michael Wooldridge, the Minister for Health and Aged Care, that the AMC take on the specialist recognition tasks previously undertaken by the National Specialist Qualification Advisory Committee.
Dr Peter O’Connor

When A/Prof Goldberg retired as Censor-in-Chief at the end of 1999 he handed over to Dr Peter O’Connor. By the turn of the century the extensive changes which had been taking place within the College’s VTP were continued and, despite initial misgivings, the College provided significant input into the development of the AMC’s accreditation process, which was designed to evaluate all specialist medical college training programs.

Peter O’Connor was born in Brisbane in 1940. He was educated at St Joseph’s Nudgee College in Brisbane and gained his MBBS at the University of Queensland in 1965. Dr O’Connor worked at the Royal Brisbane Hospital for several years before moving to Melbourne to study ophthalmology at the Royal Victorian Eye and Ear Hospital (RVEEH) from 1970 to 1972. He was awarded MACO in 1973.

As Censor-in-Chief during 2000–2002, Dr O’Connor guided education policy and operations through a period of review and change, including planning and organising for the move to a five-year program due to commence in 2004, and preliminary preparations for accreditation by the AMC in 2006. Following the decision to incorporate the ophthalmic basic sciences into the five-year VTP, the Part I Exam was discontinued and the final examination was held in February 2002.

Dr O’Connor introduced quality measures at each stage of a trainee’s progress through the VTP including the strengthening of the ‘fitness to sit’ requirement for candidates for the Part II Examination, and improvement of arrangements for each trainee’s final year experience. Early in 2001 a revised assessment form structured to record a trainee’s progress against each of the seven key roles was issued on trial for a twelve-month period. The revised form was designed to assist trainees and supervisors to identify any aspects of a trainee’s performance requiring improvement and to ensure appropriate monitoring by later supervisors as they progressed through successive posts.

By 2001 significant changes had taken place with increased scrutiny from the Australian Competition and Consumer Commission. Formal review of College direction was forecast and appropriate strategic goals were set in preparation for external accreditation. From strategic planning meetings, eight key strategic goals were identified, and major objectives referred to the QEC for action. Plans emerged: to implement systems approaches to the VTP; for continuing professional development; for the assessment of overseas trained specialists; and to improve the quality of the journal.

Assisting the Censor-in-Chief were the chairs of the seven regional QECs from each state and New Zealand, who oversaw the progress of College trainees in their regions through the cooperation of hospitals, universities and College Fellows. There were also thirteen committees, boards, and portfolios, covering all educational activities.

Dr David Kaufman

Dr O’Connor, who had guided education policy and operations through the review and change, handed over to Dr David Kaufman as Censor-in-Chief at the end of 2002. Whereas the QEC set the educational policy and directed the delivery of all education and training, in November 2002 the College decided to establish a Board to be the body legally responsible for corporate governance, including education and training. Therefore, to provide the formal link between the QEC and the Board, the Censor-in-Chief became an ex-officio member of the Board while the offices of Vice-President, Immediate Past President, Honorary Secretary and Honorary Treasurer were abolished.

Dr Kaufman was born in Melbourne in 1946. He was educated at Scotch College, Melbourne and graduated MBBS at the University of Melbourne in 1969. He worked as an intern and Senior House Officer at the Royal Melbourne Hospital before entering the ophthalmology training program at the RVEEH from 1972 to 1973 and was awarded FRACS in 1974. Subsequently he undertook post-graduate training as Clinical Lecturer at the Nuffield Laboratory of Ophthalmology, Oxford, UK, followed by a study and lecture program in the USA. At an early stage Dr Kaufman became interested in working in remote areas and served on the National Trachoma and Eye Health Project at Utopia in the Northern Territory; and as a Director of the Australian South Pacific Eye Consultant Team Foundation in the South Pacific, leading many teams to Pacific nations for teaching and surgical aid. He served as a consultant at the Royal Melbourne Hospital from 1978 to 2013, being Head of Department from 1991 to 2000.

Dr Kaufman served on the Victoria Branch Committee from 1978 to 1987 and he served on the Federal Council from 1985 to 1987, joining the RACO Library Committee in 1987. He also served as a Part II Examiner for ten years and in 1999 he took over from Dr Geoffrey Crawford as Chairman of the Committee for Continuing Medical Education (this was re-named Continuing Professional Development (CPD) in 2001 following a wide-ranging review). A new CPD framework formalising activity reporting was introduced for the 2006–2008 triennium when it became a requirement for Fellowship.

As Censor-in-Chief, in 2004 Dr Kaufman saw the introduction of the five-year training program. The implementation of the five-year VTP was a concerted process. Training Networks Managers were appointed to the College staff in 2004 and staff support was therefore increased to all involved in training. New procedures and processes were introduced while existing processes were reviewed and validated, particularly for trainees with their increased workload of exams during their first 18 months.

By 2005, first year trainees in the five-year VTP required guidance on managing their service and study commitments dealing with the ophthalmic sciences exams, therefore workshops were held to identify the issues and develop practicable support pathways to assist under-performing trainees. A new Trainee Progression Committee was set up to track the performance
of trainees, to provide advice on trainees in difficulty, and to review proposals for research and final year plans.

An important measure of external recognition of the College’s educational competence was the interim accreditation of the College’s education programs by the AMC. Accreditation was a process of putting numerous comprehensive systems and procedures in place to ensure that what was required to be done was actually being done. Formal accreditation in 2006 followed an exhaustive accreditation process with overall positive findings, although the review identified some areas for improvement.

Directors of Training were appointed for each training scheme to work closely with training supervisors and were responsible for overseeing and monitoring the training experiences and performance of each trainee. Furthermore, Training Supervisors were designated in each training location or accredited post to identify the major clinical and surgical training experiences available and to ensure training opportunities were optimised and they coordinated the assessment of each trainee’s performance with clinical tutors. Two more staff members were engaged in 2005 with special responsibility for monitoring supervised clinical and surgical training to enhance support to directors of training, supervisors and trainees.

The College was continually improving the examinations and it was decided that from 2005 advanced trainees would be permitted to sit and pass the ophthalmic pathology exams separately from the clinical ophthalmology exams. While 2006 was a year of accomplishment and ongoing challenges, at the examiners’ meeting it was agreed that passing the written exams was a necessary requirement for candidates to be invited to complete the practical clinical exams.

On completion of the matching process in 2006 for the selection of the 2007 trainees’ cohort, Dr Des Coote retired as Coordinator of the NOMP and was replaced by Dr Ralph Higgins. In 2007 New Zealand joined the NOMP for the first time and, despite the tight time frame, the matching proceeded smoothly with Dr Higgins as the coordinator for the first time.

Dr Kaufman served his last year as the Censor-in-Chief in 2008 during which Regional QEC Chairs together with Directors of Training participated in a workshop to review the VTP to define competence, improve work-based assessment, assess basic surgical skills, improve selection techniques and evaluate the VTP.

At that time the Medical Council of New Zealand resolved to reaccredit the College for six years subject to a report addressing cultural competence in its VTP and CPD programs by December 2008, and a further four years subject to a satisfactory report by the end of the fifth year. The new Social and Professional Responsibilities curriculum standard, which had been developed since accreditation in 2006, was adopted.

The Ophthalmic Sciences assessment was streamlined by putting three of the basic ophthalmic science examinations online: Microbiology, Genetics, and Evidenced-Based Ophthalmic Practice combined with the Pathology examination. The data gathered from trainees about the quality of their work-based supervision was analysed and showed that the majority were positive about the skill level of their supervisors in that they were effective planners, communicators and assessors and that their practice was underpinned by a strong evidence base. At that time concerns raised about limited trainee access to supervisors’ time were pursued with individual training networks.

Dr Mark Renehan

On the retirement of Dr Kaufman as Censor-in-Chief at the end of 2008, there was a seamless transition to Dr Mark Renehan as his replacement. In the role of Censor-in-Chief, Dr Renehan carried on with the developments in education and training initiated by his predecessors and accomplished many advances.

Mark Renehan was born in 1958 at Ivanhoe, Victoria. At school he was conscripted into cadets and promoted to the rank of Corporal. He attended Monash University and graduated MBBS in 1988. To Dr Renehan and his cohort, Monash University was affectionately known as 'The Farm' as it was an old epilepsy asylum surrounded by mud. Mark trained to become an ophthalmologist through the RVEEH training scheme from 1989 to 1992 and graduated as FRACO in 1993. During his ophthalmology training he was involved in a large ocular trauma research project. However, because the ‘leader’ of the project published without acknowledging the co-researchers, Dr Renehan’s research fire was put out. Nevertheless, he taught fourth, fifth and sixth year undergraduate medical students at Monash then undertook post-graduate registrar teaching, both clinical and operative. Dr Renehan served on the Medical Advisory Committees of Shepparton Private Hospital and the Medical Advisory Committee of The Bays Hospital Inc., Mornington Peninsula, and has been on the Board of that institution since 2013.

He was a Member of the Victoria Branch Committee of RANZCO and was on the Board of the Centre for Eye Research Australia when he was Chair of the Branch in 2000. He became a Councillor of the College in 2000 and has served on the Health Policies and Priorities Committee. He was elected to the RANZCO Board in 2004 and continues as an ex officio member as Censor-in-Chief. Mark served on the QEC as a physiology examiner for the Part I exams, and in 2003 he was elected as Chair of the Part I Board of Examiners. He assisted in steering the changes from the Part I Examination through to the Ophthalmic Sciences exams, and was re-appointed as the Chair in 2006. He also served as an Inspector of Posts for Accreditation, and is a member of the Overseas Trained Specialist/Specialist International Medical Graduates (OTS/now S-IMG) Committee.

As planned, the behavioural capabilities assessment for the selection of trainees had been
reviewed and was withdrawn while support for selection committees in 2009 for 2010 was upgraded by developing and coordinating sources of information on applicants structured with registration form, reference template for referees to complete online, and behaviourally-focused interview questions. The selection criteria continued to be the seven key roles of the specialist ophthalmologist and the matching program remained unchanged while the integration of basic sciences study and needs of the service role of trainees in the hospitals was under constant review.

At that time new training positions, particularly in paediatrics, were sought. Support for supervisors was strengthened with the publication of a Trainers’ Handbook, a source of practical guidance including trainee remediation. Work-based assessment of trainees continued to be based on three key assessment meetings: at the beginning on intentions for the term; informal feedback mid-way through the term; and towards the end of the term with reports from clinical tutors. The assessment was then discussed with the trainee before they moved on to their next post.

Examination changes were sustained through evaluation feedback and training for all examiners. Online examinations were successfully launched for three ophthalmic sciences subjects that trainees may perform at times of their convenience and the General Pathology examination was discontinued and instead incorporated into the Ophthalmic Pathology examination for trainees in their third year. Pathology examiners decided to use advanced computer-based imaging in place of the microscope viva in the new, integrated ophthalmic pathology examination for third year trainees in 2010.

The first full curriculum review for all ophthalmic sciences and pathology subjects was completed over a two-year period with involvement of supervisors, trainees, examiners and College managers across all networks. Another was commenced in 2012 ensuring that all curriculum standards were revised or expanded to incorporate new technology and recent developments into training.

In a two-day pilot workshop funded by the Commonwealth Department of Health and Aging, there were fourteen second-year trainees who were trained in communication competencies as set out in the Social and Professional Responsibilities standard. That was achieved by using simulation techniques and trained actors through structured role-play scenarios to teach communication skills for inter alia breaking bad news. The trainees experienced complex communication situations and gained feedback on their communication styles, which increased their understanding of the impact on their performance.

In 2011 Dr Renehan was elected to the Steering Committee for the International Development Committee, contributing to the capacity building of the Pacific Eye Institute in Fiji. He signed a Memorandum of Understanding with Prof Saphonn Vonthanak in Phnom Penh representing a continuing collaboration between RANZCO and the University of Health Sciences (UHS) to ensure high quality ophthalmic education and professional standards for eye care in Cambodia. He also contributes to ophthalmic education and professional standards for eye care in Timor Leste.

Dr Renehan also promulgated the introduction of Temporary Trainee Associate Membership for prospective trainees who had not been selected onto the training program after being through the selection process but who filled vacancies in accredited training posts created by maternity or paternity leave.

Ms Margaret Dunn
RANZCO Honorary Fellow

Note: This article has drawn from a number of different references. For a full list, please email Ms Margaret Dunn at margaretdunn@bigpond.com.
The last few months at RANZCO have been extremely busy for staff and the many Fellows giving their time. In particular, we have been focussed on implementing a clear plan to address the conditions and recommendations of the Australian Medical Council and Medical Council of New Zealand accreditation process. This involves not only the Education Team but all areas of RANZCO.

The initial focus has been on improving our policies and procedures as they relate to training, and by extension on-going education. In particular, we now have a new policy for Reconsideration, Review and Appeal of College decisions that affect trainees, Specialist International Medical Graduates and all other members. We also have a new Complaints Resolution Policy and a Conflicts of Interest Policy. These are all available on the RANZCO website. The purpose of these additional or updated policies is to provide improved transparency in decision making, allow easier access for those wishing to make a complaint or dispute a decision, and provide better guidance to those tasked with assessing complaints or adverse decisions. This is only the beginning as we are currently undertaking a review of the Professional Code of Conduct to ensure that it also provides appropriate standards of behaviour that can be assessed if necessary and action taken if required. This is clearly an area that needs careful consideration and will involve extensive consultation.

The main focus of RANZCO remains the training of new ophthalmologists and the ongoing education throughout their careers, which will become even more important as the whole medical profession moves towards revalidation. Our new Deputy CEO and Head of Education, Ruth Ferraro, and Censor-in-Chief, Dr Justin Mora, have been working very closely to reframe our educational offerings in line with accreditation requirements and member and community expectations. This will become more apparent over the rest of 2017, but one outcome is the creation of a new role, Dean of Education, which will be a part-time staff member, ideally an ophthalmologist, providing subject matter expertise and advice to RANZCO staff as required. They will be closely involved in curriculum development for trainees and ongoing professional education resource development. Many other colleges have a similar role, working closely with education staff and Censors-in-Chief. This will allow Justin and Ruth more time to address the day to day needs within the training networks and focus on raising overall educational standards.

Finally, we will soon lose three members of staff to maternity leave. Alex Arancibia (General Manager – Membership), Antonelle Clemente-Marquez (Manager – Selection & Assessment) and Felicity Tripolone (Coordinator – Basic exams & Training post accreditation) are all due in May. I wish them all the best during their time off with their expanded families and we look forward to welcoming them back.

In March we also saw the retirement of Lee Cummings after six years as our Coordinator of Specialist Training Posts (federal government funded, mostly regional, positions). Lee initially joined us for what was expected to be only a short time, but we were very fortunate he stayed much longer. I am very pleased that existing staff have agreed to manage the redistribution of work, or it will be covered by temporary staff, without significant impact to the business.

Dr David Andrews
Chief Executive Officer, RANZCO
Applications now open for the Avant Doctor in Training Research Scholarship Program 2017

Avant understands the pressures you face as a doctor in training. Making a contribution to medicine through research is rewarding and it can also be one of the best ways to enhance your career. That’s why Avant is pleased to offer the Avant Doctor in Training Research Scholarship program again in 2017. The program offers $450,000 in funding across a total of 20 scholarships and grants for full-time, part-time and short-term research projects.

So if you’re conducting research as part of your training, apply for a scholarship.

Pictured: Dr Georgia Kaidonis – Ophthalmology registrar, Avant Doctor in Training Research Scholarship 2014 recipient

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Advancement of medicine
Research which contributes to developing improved health and medical practices e.g. diagnostics, drug therapies, biological processes, quality of life and health promotions.

Quality in medicine
Research designed to improve quality e.g. focus on systems, processes, functions or a combination. Must relate to a domain of quality e.g. (safety, effectiveness, appropriateness, acceptability, access, efficiency) Site specific e.g. hospital or multi-site projects

Emerging Researcher*
Part-time
2 x $25,000
Full-time
2 x $50,000
Part-time
1 x $25,000

Experienced Researcher*
Part-time
2 x $25,000
Full-time
2 x $50,000
Part-time
1 x $25,000

Grants
6 x $12,500
- Obstetrics, gynaecology and women's health
- Anaesthesia, perioperative and pain medicine
- Medicine (includes paediatrics, radiology and pathology)
- Surgery
- General practice, community, rural and remote medicine
- Mental health

Financial assistance to support short-term periods of research. Research is expected to be less than 12 months, however research of more than 12 months is not expressly excluded.

Who can apply?
Applicants must be:
- an Avant member with a professional indemnity insurance policy with Avant Insurance Limited under one of three categories:
  - Intern
  - Resident Medical Officer
  - Doctor in Training
- an Australian citizen, New Zealand citizen or permanent resident of Australia
- registered with the Medical Board of Australia enrolled in:
  - a specialist research training program recognised and approved by the relevant Australian/Australasian college and accredited by the Australian Medical Council (Specialist in Training), or
  - a research program with a recognised academic institution working towards a post-graduate degree such as a masters or PhD, or
  - a formal research program with at least one appropriately qualified research supervisor, with research commencing on or before 30 March 2018.

Not a member?
Join today visit avant.org.au/join
For more information, eligibility requirements and full terms and conditions visit avant.org.au/scholarships.
Membership Spotlight

RANZCO Human Research Ethics Committee

For each calendar year, the National Health and Medical Research Council requires an annual report of institutional human research ethics committee activities. In the past, this information was gathered using fillable PDF forms, but more recently the answers to the detailed questions are obtained using an online form which is conducted by ORIMA Research.

The information gathered from RANZCO’s Human Research Ethics Committee (HREC) and other registered committees is amalgamated together into a single activity report and ultimately provided to the Australian Health Ethics Committee, providing an overview about the Australian Human Research Ethics Committee system.

The composition of human research ethics committees is important and there are several categories which must have representation including a Chair; two lay persons (male and female); a person with knowledge of, and current experience in, the professional care, counselling or treatment of people; a pastoral care person; a lawyer and persons with knowledge of, and experience in, the areas of research regularly considered by the human research ethics committee. That last category for RANZCO is of course ophthalmologists involved in research and our Committee has four Fellows who fit that category.

In previous articles we have profiled HREC members and this time we are focusing on the male lay person Brad Sheehan.

Brad brings a wealth of industry and regulatory experience to the Committee. As well as being a trained Registered Nurse he has further qualifications in critical care and business management. Brad has additional expertise in quality management, auditing, regulatory affairs, risk management and Good Clinical Practice (GCP) and has worked in the clinical research and medical device industry for many years.

“In my current role as a Director of Five Corners Medical Device Consultancy firm I have day to day engagement with key stakeholders in medical research and the device industry. Five Corners has engagement in every stage of medical device development, from the initiation of first-in-man clinical trials through to post-marketing regulatory and listings processes. Our clinical research arm provides assistance with development of trial protocols, patient information and other study documentation. We guide sponsors in management and reporting of research data (including safety reporting). Our regulatory department liaises with sponsors, manufacturers and relevant government bodies to ensure all requirements relating to provision of safe medical care for the community are adhered to. “This skill and knowledge base enables me to expertly assess research design and merit. This ability to make effective decisions on research validity is an important role of the Committee. Arguably more important is the ability to draw on my past clinical experience and knowledge of GCP to assess any project from a participant perspective. The assessment of beneficence of any clinical trial is vital. I have an in-depth understanding of how to present scientific information in a manner that the general, lay community would be able to comprehend and feel comfortable with.”

In the next edition of Eye2Eye we anticipate interviewing other RANZCO HREC members.
Clinical and Experimental Ophthalmology Special Issue – Systemic Disease and the Eye

The RANZCO scientific journal, *Clinical and Experimental Ophthalmology (CEO)*, publishes an annual special issue, which consists of invited review articles from world experts based around a central theme. This year the focus is on systemic disease and the eye. The topic is an important one, as the ocular manifestation of a systemic disease or congenital condition may be its first visible presentation.

The issue was published in February, and contains eight major review papers. Readers can learn about the ophthalmic manifestations of tuberous sclerosis, gout and uric acid crystal deposition, Alzheimer's disease and multiple sclerosis. Other articles present the systemic associations of corneal deposits, primary open angle glaucoma, and retinal microvascular changes. The issue also includes a major review of hypertensive eye disease.

The issue has been offered as free content to enable all readers, even non-subscribers, to read these major reviews. To access this issue, or any other CEO articles from issue 1 in 1973 to the current issue, simply login to the members section of the RANZCO website, and click the 'CEO Journals' link.
What a great start to 2017. I am happy to continue as Chair of the Younger Fellows Advisory Group for another term, having had a successful year as interim Chair.

The Group was originally formulated four years ago and has expanded rapidly to include representatives from each state and New Zealand. The group aims to represent younger Fellows and address any issues that any younger Fellow may have at a College level. I am exceptionally pleased at the interest for many newly graduated younger Fellows to join our group, which makes the group quite dynamic.

Currently, our group has the following members:

- Dr Nisha Sachdev (Chair)
- Dr Kenneth Chan (NZ)
- Dr Jesse Gale (NZ)
- Dr Narme Deva (NZ)
- Dr Chameen Samarawickrama (NSW)
- Dr Andrea Ang (WA)
- Dr Tom Cunneen (WA)
- Dr Shane Durkin (SA)
- Dr Matthew Little (SA)
- Dr Zoe Gao (Tas)
- Dr Nathan Sachdev (NSW)
- Dr Jennifer Fan Gaskin (VIC)
- Dr Xavier Fagan (VIC)
- Dr Nathan Walker (Qld)
- Dr Todd Goodwin (Qld)
- Dr Andrea Ang (WA)
- Dr Tom Cunneen (WA)
- Dr Shane Durkin (SA)
- Dr Matthew Little (SA)
- Dr Zoe Gao (Tas)

I am excited about the new Fellows that have joined our group recently and look forward to working with everyone.

We had a successful 2016 with many younger Fellows’ events throughout the year. The highlight, of course, was the RANZCO Annual Scientific Congress in Melbourne.

RANZCO Congress 2016

The 2016 Annual Scientific Congress was held in the beautiful and vibrant city of Melbourne. Last year, again, was another successful Congress for younger Fellows.

For the second year, we hosted a course for younger Fellows at Congress. I was delighted to have Dr Andrea Ang, who is also on the Younger Fellows Advisory Group, as Co-Chair for this course. Dr Brad Horsburgh, our College Past President, provided an oversight of the role of the College for younger Fellows and outlined the College composition with how younger Fellows can be more involved. Drs Con Moshegov and Stephen Best provided an entertaining insight into how to deal with a difficult patient and provide a second opinion. This was superb in construction and delivery, generating a lot of discussion and thought-provoking comments. The final speaker was Deb Jackson, a lawyer from MDA National who illustrated how to minimise your medicolegal risk with social media with interesting cases, which is definitely a topic of interest in regard to the current and future generations of ophthalmologists.

Our social event at Congress last year was, of course, the Younger Fellows Dinner, which was generously sponsored by Avant. Seventy-seven Fellows attended and we had a fantastic evening. It is a great way to catch up with all of our colleagues who we trained with for many years and to share our unique experiences of being a Fellow.

Last year, we welcomed 33 Fellows into the ophthalmic fraternity. And yes, what another successful year for new Fellows! It is fabulous to see many Fellows graduating whom I know personally. Last year was unique...
for me, as many Fellows who were graduating were those who I had taught as trainees. It is such an endearing and heartfelt experience seeing them standing on stage receiving their fellowship. It is such a privilege to now welcome them into the ophthalmic fraternity.

Younger Fellows’ input to the scientific content

I was exceptionally delighted and impressed with the number of younger Fellows that were presenting at Congress at different symposia and courses. There are too many to discuss individually, however, there were certain presentations that were impressively noticeable. At the Ophthalmic Research Institute of Australia (ORIA) session, researchers presented their work that has been performed with funds received from ORIA.

Professor Angus Turner has revolutionised eye care in Western Australia for Indigenous Australians. He presented not only his work in setting up the Lions Outback Van but discussed issues in order to collaborate with optometry. Professor Alex Hewitt presented research his lab is performing on the genetics of inherited retinal diseases which is very interesting. It was impressive to see the calibre of work these younger Fellows are doing!

An additional session of interest was ‘Cataract Surgery in a Low Resource Setting’ since I am currently a surgeon on an aid trip to Vietnam and Cambodia. Dr Matt Ball gave a fabulous historical perspective on his experience in Nepal, outlining his time on the Fred Hollows Foundation and how he learnt small incision cataract surgery. It is great to see other younger Fellows interested in volunteer work throughout the developing world.

Many other younger Fellows were presenting throughout Congress on various clinical and research topics, which was a pleasure to see.

The social highlight of Congress was obviously the Congress dinner at the Melbourne Cricket Ground. This was an exceptional venue – accolades to the Congress Committee for organising a great venue. And the MC of the evening, Dr Xavier Fagan, enriched our evening with a script full of humour and flair, which was very entertaining.

Events for 2017

I hope that 2017 is another successful year for younger Fellows. Several events are already coming into place. My aim from taking over as Chair last year was to increase the presence of younger Fellows in state Branch meetings. This will provide another avenue for younger Fellows to congregate and socialise with their peers, with the additional hope of providing some non-clinical educational content.

I am pleased to report that all representatives have been working diligently in collaboration with the Branch Committees to co-ordinate an event at each Branch Annual Scientific Meeting.

NSW Branch Annual Scientific Meeting

I am organising a lunchtime symposium during this ASM with a lawyer presenting on advertising/branding/marketing and medicolegal cases of interest.

Vic Branch Annual Scientific Meeting

The Victorian representatives are organising a cocktail function during the ASM. As we have updates about other activities across all Branches, we will send out further communications.

Dr Nisha Sachdev
Chair, Younger Fellows Advisory Group
Applications Opening for Macular Degeneration Research Grants

Macular Disease Foundation Australia’s Research Grants Program opened its fourth round of grants on 1 March 2017.

Grants are open to researchers based in eligible Australian institutions to pursue research into medical, social, low vision, and nutritional research of macular degeneration. Grants for Australian researchers undertaking research with international partners is also available.

The grants are awarded following rigorous evaluation, based largely on the National Health and Medical Research Council process, along with international peer review, to ensure that the successful applicants meet the highest standards.

Researchers wishing to apply need to note:
• Applications open - 1 March 2017
• Applications close with electronic submission - 5 June 2017
• Successful applicants will be announced on World Sight Day - 12 October 2017

Full instructions, application forms and other relevant information is available for download from Macular Disease Foundation Australia’s website. Visit www.mdfoundation.com.au

Macular Disease Foundation Australia is the leading not-for-profit organisation funding peer reviewed research into age-related macular degeneration in Australia. The Research Grants Program was launched in 2011 to support the Foundation’s mission to reduce the incidence and impact of macular degeneration. To date, over $3 million has been committed to world leading Australian researchers. This year’s investment into research will be $800,000, including $200,000 from the Blackmores Macular Disease Foundation Australia Grant for research into nutrition, lifestyle and practices of eye health professions.

Macular Degeneration Awareness Week 2017

In support of Macular Degeneration Awareness Week 2017 (Sunday 21 – Saturday 27 May) Macular Disease Foundation Australia is once again calling on all eye health professionals to support our campaign.

This year’s theme is Face the Facts.

It will highlight prevention and early detection through an eye test and macula check for the at risk 50+ age group.

Your MDAW kit - coming soon!

You will receive your Macular Degeneration Awareness Kits and digital assets in late April, so you can plan promotional activities and order your free resources in the lead up to the week.

For further information, contact Macular Disease Foundation Australia on 1800 111 709 or visit www.mdfoundation.com.au
Eye2Eye Autumn 2017

Book Review - *Smitten by Catherine*

Searching for a gift at an auction house in Melbourne, the author comes across a magnificent eighteenth-century watercolour painting by Rubens, listed as ‘Attributed to Catherine da Costa’. What follows is a curious search for the story behind the woman who inspired a masterpiece, Catherine da Costa.

*Smitten by Catherine* is a journey of discovery for Melbourne based ophthalmologist, Dr Henry Lew, and reveals the history not only of Catherine da Costa’s family but also of Jews in 16th, 17th and 18th century Spain, Portugal and England.

This is a well written and thoroughly researched account chronicling the life of a remarkable woman who is now recognised as the first ever recorded female Jewish painter, the first English-born Jewish artist in recorded history and only the second English-born female artist in recorded history. In his book, Dr Lew captures the incredible never-before-told story of Catherine da Costa, explores her links to British royalty and details the struggles of Sephardic Jews at the time.

This is a truly inspiring story that features beautiful illustrations throughout, with artwork from the 16th, 17th and 18th centuries. *Smitten by Catherine* is a must-read for anyone interested in art, Jewish history and history in general.

**Maheen Imam**
*Communications Officer, RANZCO*

**About the author**

Dr Henry R. (Harry) Lew has practiced ophthalmology full time for 40 years. His aim has always been to have a warm and caring relationship with his patients, and to keep them seeing as well as possible for as long as possible. He was trained at the Royal Victorian Eye and Ear Hospital (1975-1977), where Professor Gerard Crock was his principal mentor; was a Fellow in ophthalmology at Leeds General Infirmary in the UK (from 1978-1979), where he did Retinal and Paediatric Fellowships; took over from Professor Crock as Visiting Senior Surgeon, Repatriation General Hospital, Heidelberg (late 1979-2007), and was also a Visiting Surgeon at the Royal Victorian Eye and Ear Hospital (1980-1984). He has lectured, written, and made movies on various ophthalmological subjects such as Manual Small Incision Cataract Surgery, Diagnostic and Surgical procedures with respect to Glaucoma, and some unusual aspects of Oculo-Plastic Surgery including Immunotherapy. In his spare time, he has written six books: *Horace Brodzky* (1987), *In Search of Derwent Lees* (1996), *The Five Walking Sticks* (2000), *The Stories Our Parents Found Too Painful to Tell* (2008), *Lion Hearts* (2012) and *Smitten by Catherine* (2016).
With a new year comes new exciting change. We welcome on board the Practice Managers Committee Kharissa Cain as the new Chair and Lucy Peters as Deputy Chair, with the addition of Judith Parnell, Lara Reindl and Gail Drennan as new members. We are keen to introduce some of the members and find out more about them and their lives as practice managers. This gives us the opportunity to talk to Kharissa, Lucy and Gail and ask them a few questions about their work, role and life in general.

Kharissa Cain – Kingswood Eye Centre (SA)
Kharissa has been working at Kingswood Eye Centre in South Australia since June 2013. Kingswood Eye Centre currently has four doctors and the Centre recently relocated to new purpose-built rooms so there is scope for expansion and the number of doctors and specialities to increase in the coming years. Kharissa is also a mother of four ranging from 5 to 21 years of age, so as you can imagine life is pretty crazy. But having just recently built their new family home, she has started to enjoy interior design and wastes a lot of time on Pinterest these days.

Q What year did you go into practice management? What were you doing before and what made you decide to move into primary healthcare?

A I have been working in the health industry in administration in various roles for over 16 years. I returned to work from maternity leave in 2012 on a part time basis after having my daughter and felt that I needed more of a challenge and wanted to try something a little different – ophthalmology is vastly different to orthopaedics or medical imaging. I saw my current position advertised, which was for a part time practice manager, which suited the needs of my family, but felt would give me the challenge in my career I was searching for. So I decided to apply and, thankfully, was successful.

Q What have you found to be the biggest challenges to this job?

A There have been lots of challenges along the way and probably one of the biggest challenges is balancing the demands and expectations of patients, staff and doctors.
Q What are the best parts of the job?
A I have thoroughly enjoyed the last 6-12 months of my role being involved in the design, construction and relocation of our new purpose-built rooms. It has certainly been a journey but the end result is fantastic. I also love working with the staff to develop and implement guidelines/procedures etc., to enhance the patient experience.

Q If you could give one piece of advice to a brand new practice manager, what would it be?
A Become a RANZCO Practice Managers member, access the forum we are developing on the website to be able to access the wealth of knowledge your colleagues can provide. Most of us are dealing with similar issues and to be able to share knowledge or resources amongst ourselves is invaluable.

Q How long have you been on the Committee and what led you to take on the role of Chair?
I joined the Committee at my first RANZCO Congress in Brisbane in 2014 and have enjoyed the network I have created in that time. I was nominated to be Chair after Lisa Hartley decided to step down from the role after two years. I hope with Lisa’s guidance and that of other Committee members, as well as Keo from RANZCO, we can develop an exciting and dynamic conference in Perth this year.

Lucy Peters – Gordon Eye Surgery (NSW)
Lucy joined the Gordon Eye Surgery team in 2009 and works with 18 wonderful ophthalmologists and specialists including the four owners: A/Prof Geoffrey Painter, Dr Sara Booth-Mason, A/Prof John Grigg and Dr Brian Chua, and a fantastic team of 25 support staff.

Q What year did you go into practice management? What were you doing before and what made you decide to move into primary healthcare?
A I became a practice manager just last year, before that my role was assistant practice manager for five years combined with being a surgical coordinator for two years. I decided I wanted to work in management early in life being the organiser amongst my social group and the leader during activities, but healthcare management became my passion when I spent time working in a GP surgery and at Great Ormond St Children’s Hospital in London during my gap year before university. Healthcare struck a chord with me due to the ability to communicate with so many different people in all walks and stages of life, the fast paced environment that just makes time fly, and, in addition to the stability and structure healthcare provides, the technological advances appealed to my experience growing up with a father who built my first computer when I was eight years old and learning programming through primary school. Had I stayed in the UK I would have followed the NHS management program but during this same year I met and fell in love with my husband-to-be (and Australia) on my travels and moved here after university where I then began my journey into ophthalmology.

Q What are the best parts of the job?
A Working in ophthalmology is extremely rewarding. Patients are always grateful, which is a lovely atmosphere to be around, and being able to help ease the journey through diagnosis and treatment is a great motivator. Working with such amazing doctors is a privilege, particularly hearing about their research, advancements, successes and overseas charity operations. The technological advancements are fast paced and keep life interesting, and the team work involved in a healthcare practice is a wonderful culture to work within.

Q What have you found to be the biggest challenges to this job?
A Definitely time management, which I am still coming to grips with! I’d become used to the idea of the never-disappearing, ever growing ‘to do list’ (which is of course a healthy sign of continuous improvement!) but learning to prioritise and allocate appropriate resources to each of the eight core principles of healthcare practice management equally is an ongoing learning curve. Ask me again next year!

Q If you could give one piece of advice to a brand new practice manager, what would it be?
A Mentorship and education. I have been very lucky at Gordon Eye and could never have got this far without the guidance, support and leadership of my mentor Donna, and the support of the principals. The AAPM/UNEP education pathway has been extremely valuable, and I would encourage all new (and indeed aspiring and existing!) practice managers to check out the Certificate IV & Diploma, and to become Certified Practice Managers by keeping up with CPD. Attending the annual RANZCO Practice Managers Conference is also a big must, as not only does it provide excellent education sessions (leading to more items on the improvements to do list!) and updates on the latest in the ophthalmological community, but also the networking opportunities are invaluable - to talk with people who are like-minded and on the same page is reassuring, as well as the ideas and solutions shared.

Gail Drennan – Perth Eye Hospital (WA)
Gail Drennan is currently employed at Perth Eye Hospital (PEH) in a full time role as patient administration manager, entering her ninth year. Gail was initially employed as a receptionist and after a period of two years was offered a position of administration manager, supervising four staff. As she had previous experience in a similar
job, she accepted knowing she had the required attributes for the role. The newly refurbished day hospital is two and a half times the size of the previous facility, now operating from a brand new state of the art science facility with four theatres, five bay recovery suites and a second stage recovery lounge. Over the past nine years, PEH has grown to 70-plus staff, 10 of whom are under Gail’s direct control, and 30 surgeons are now performing nearly 9,000 procedures each year.

Q What year did you go into practice management? What were you doing before and what made you decide to move into primary healthcare?

A I started working in the medical profession back in 1977 when Medibank Private was first established. I stayed there for 13 years and not only gathered a great grounding in health fund processes but also jump started my passion for the medical industry. After taking several years off to raise two daughters, I recommenced my work in the medical field at Bethesda Private Hospital in admissions, gradually taking on a role as Supervisor of the Day Procedure Unit. I was employed there for over 10 years before a position became available in 2007.

Q What have you found to be the biggest challenges to this job?

A I would say that my biggest challenge and responsibility involves the interviewing, hiring and training of suitable employees for the front desk, as this is the first and often the most important initial contact for our patients. Conducting performance evaluations and, where appropriate, developing plans to improve our patient services are considered very important. We also need to maintain a high level of professional care for all of our customers, clients and employees. It is essential to build a cohesive team and to keep staff motivated to deliver the highest standard of care.

Q What are the best parts of the job?

A I enjoy interacting with employees on all different levels of the organisation. I have been dealing with patients, carers and the public for many years now and feel my vast experience in this area has held me in good stead over the years.

Q Why did you join the RANZCO Practice Managers Committee?

A I like to interact with other practice managers and have enjoyed discussions of all aspects of the role and challenges we all face. It has enabled me to keep in touch with changes as well as new developments. I remain very interested in where eye surgery and practice management is headed in the future. Having joined the Committee at the start of 2017, I am looking forward to being part of this year’s conference!
Australian Ophthalmic Nurses Associations Formalise National Council

During the 2016 RANZCO/AONAVIC Melbourne Conference, representatives of state-based Australian Ophthalmic Nursing Associations formalised the Australian Ophthalmic Nurses Associations National Council (AONANC) to strengthen the profession’s national voice and support professional development.

“The Council will not remove or replace state-based associations,” said elected AONANC Chair Joanna McCulloch. “Instead it will support and encourage each region to work together on nationally relevant items, such as ophthalmic nursing standards, statements and qualification frameworks.

“Our members, collegial partners and, ultimately, our patients will gain the most from this development as we will be able to provide a clear voice and direction within both the nursing and eye care sectors.

“Our Partner Representatives, who have been working tirelessly for several years to bring AONANC to fruition, are looking forward to working towards agreed goals and, of course, engaging with external peer professionals whose passion for eye care matches our own,” added Ms McCulloch.

The key aims of AONANC

a. Provide professional representation for ophthalmic nurses.
b. Develop and maintain national standards, statements, and recommendations relating to the practice of ophthalmic nursing.
c. Provide expert clinical advice and collaboration, if requested, for any post graduate education or ophthalmic learning opportunity.
d. Seek to include ophthalmic nurses in the wider national and global vision dialogue and strategies, and their participation in sector initiatives.
e. Provide a national point-of-contact to other external stakeholders and interested parties wishing to engage the national ophthalmic nursing community.
f. Encourage member engagement and collaboration with national research and innovation projects and opportunities.
g. Share information on meetings, conferences and workshops and support the publication of national newsletters.
h. Promote the profession of ophthalmic nursing.
i. Act as the national consultative body on issues affecting ophthalmic nurses.


AONANC wishes to acknowledge Pam Armstrong – Vic. and Signatory Observers: Anne Huigen – NT, Anne Lentakis – SA, and Dierdre Myers – Vic., for their support and involvement towards nationalization.
Orthoptics Australia (OA) has a new president! Allow me to introduce Julie Hall. Julie was elected OA’s newest president and started in this new role as of November 2016.

Julie graduated with a Bachelor of Orthoptics in 1984, moved to Brisbane in search of an orthoptic job and has been living and working there ever since. She currently works at Vision Australia and has recently been appointed Regional Practice Leader.

Julie loves that there is something new and different to see everyday working as an orthoptist. “A parent with a child or an adult with newly acquired vision loss may be angry or grieving so the orthoptist becomes the accidental counselor. At Vision Australia, the orthoptist does a lot of problem solving within the role, we need to think outside the box. Orthoptists may work across many different eye related areas: paediatrics, low vision, laser, general ophthalmic work, electro diagnostic work, research and in leadership roles.”

When asked what the best thing about her job is, Julie responded, “The team members that I work with are fantastic and so supportive, however, the most important thing is the client. Our work in low vision makes a difference to their lives so that the client can live the life they choose.”

As well as introducing our new president for 2017, OA also celebrated Orthoptic Awareness Week in early March this year. This is a very important event in the Orthoptics Australia calendar each year. Orthoptics dates back to the late 19th century but is still poorly recognised and understood by the public. During Orthoptic Awareness Week, orthoptists from all around Australia come together to promote and celebrate the orthoptic profession and spread the word about orthoptics.

This year Orthoptic Awareness Week was held from Monday 27 February to Friday 3 March and the theme was ‘Open Your Eyes to Orthoptics Australia Wide’. Each day featured a different state of Australia and highlighted orthoptists from these states and the work they do. We wanted to showcase the diverse skill set orthoptists have and the different workplaces and patients they see.

OA would like to thank RANZCO for their continued support and help in promoting the orthoptic profession.

Allanah Crameri
Orthoptics Australia PR Coordinator
Following a hugely successful RANZCO Congress in Melbourne last year, this year’s Congress will be held in Australia’s sunniest capital city. Taking place in Perth’s recently renovated and innovatively designed Convention and Exhibition Centre from 28 October to 1 November, the RANZCO Congress will once again bring together some of the world’s leading ophthalmic specialists under one roof.

The program is already beginning to take shape with information about keynote speakers, not to mention the all-important College social events, available on the Congress website at www.ranzco2017.com.

RANZCO Congress was last held in Perth in 2007 and we are very excited to be returning to this unique city. Perth’s CBD is compact and easily navigable, with excellent walking routes and transport options. The city centre is within easy reach of excellent beaches, beautiful wineries and rugged bushland. Within the city centre itself, Kings Park and Botanic Garden is one of the largest inner-city parks in the world and will be the setting for the Congress Dinner.

From the Congress venue, the Perth Convention and Exhibition Centre, delegates can take in views of the city and the magnificent Swan River. Perth is undergoing rapid redevelopment, with new cafes, restaurants and bars popping up in all areas of the city. In fact, the way it is going, Perth’s food and coffee culture may soon rival even that of Melbourne.

In addition, following much feedback from our environmentally conscientious Fellows, 2017’s Congress will see RANZCO begin the process of reducing the environmental footprint created by the Congress. The Local Convenors are keen to reduce the amount of wastage we often experience with regard to satchels and the program handbook. For Perth, we will not be producing satchels and the program handbook will not be available as standard. However, we know that some Fellows do rely on the program handbook and so any Fellows who wish to receive one can ‘opt-in’ during the registration process. A pocket program, which will fit neatly inside your lanyard, will be available for everyone at the Congress.

In the meantime, please keep an eye out for calls for courses and symposia for the 2017 Congress and speaker nominations for the 2018 Congress. All invited speakers, courses, symposia and other Congress content are a direct reflection of nominations and abstracts submitted by the Fellows of the College. It is your Congress and your ideas and contributions shape the content.

Finally, for anyone who missed the 2016 Congress or if there was a particular session that interested you, all abstracts are available online through the Wiley Blackwell-hosted Congress site at www.ranzcoabstracts.com. On this site you can search, flag and print abstracts. In time, the website will include all abstracts from past Congresses. As the 2017 Congress draws near, the accepted abstracts will be uploaded onto the site in enough time for you to review them before the start of the Congress.

We look forward to seeing you in Perth!
Australia is on the verge of closing the gap for vision in Indigenous eye health and this is potentially achievable by 2020 – only three years away.

The University of Melbourne Laureate Professor Hugh Taylor believes that continuing the work reported through the Roadmap to Close the Gap for Vision for the next three to four years, with adequate funding, will close the gap in the four areas of eye health that account for 94% of vision loss in Indigenous Australians.

Trachoma is on track to be eliminated by 2020; cataract vision loss can be restored, with approximately 4,000 Indigenous Australians requiring cataract surgery each year; diabetic retinopathy blindness can be prevented in 23,000 Indigenous Australians with diabetic retinopathy each year; and refractive error can be corrected for 42,500 Indigenous Australians each year by giving them glasses.

Indigenous Eye Health at the University of Melbourne estimates that $20m in funding is needed each year for four years. $10m is a continuation of current funding and $10m is a new commitment. The additional $10m in funding will ensure the remaining Roadmap recommendations are fully implemented, with ongoing separate funding not required after 2020 (McKinsey, We are nearly there, 2016).

Remarkable results in Indigenous eye health have been achieved and in only a few years the gap for blindness has been halved, with the rate of blindness in Indigenous Australians reduced from six times the rate seen in non-Indigenous Australians in 2008 to three times in 2016. The prevalence of trachoma in Indigenous children has gone from 21% in 2008 to 4.6% in 2015 after implementation of the World Health Organization’s SAFE Strategy. Contributions by all stakeholders from local communities and health services to the Australian government have contributed to these outcomes.

Roadmap recommendations are well on the way to being fully implemented; 11 of 42 recommendations have been fully implemented and all are on track to be implemented by 2020 (with appropriate funding commitment). Eighteen regions, making up over 40% of the Indigenous population, have begun implementing specific Roadmap recommendations and progress has been made and planning is underway in every state and territory (IEH, 2016 Annual Update, 2016). The Grampians region in Victoria is an example of a region that has been successful in improving eye health outcomes with a five-fold increase in optometry services, a 10% increase in annual diabetic eye checks, cataract surgery waiting lists reduced to zero and a 58% increase in provision of subsidised spectacles (IEH, Grampians – closing the gap in Indigenous eye health, MJA 2017).

The Roadmap also exemplifies the importance of establishing widespread collaboration and support. Over 80 local Indigenous communities and 550 people were involved in the development of the framework. Sector collaboration involves eight peak bodies, NGOs, federal and jurisdictional government and regional support. The Roadmap, in addition, provides a template for coordination and integration of health care for other conditions to meet population-based need, including the local planning and coordination of visiting specialists and integration of primary care and secondary specialist care. Monitoring and reporting of performance is pivotal to ensure progress is maintained through program roll-out and this will be assisted by national reporting expected through the Australian Institute of Health and Welfare in early 2017.

A national ‘Close the Gap for Vision by 2020’ conference was held in Melbourne on 16-17 March 2017. The conference is designed for those working in all aspects of Indigenous eye care: from health workers and practitioners, to regional and jurisdictional organisations. It included Aboriginal Community Controlled Health Organisations, NGOs, professional bodies and government departments. The topics for discussion included:

• Regional approaches to eye care;
• Planning and performance monitoring;
• Initiatives and system reforms that address vision loss; and
• Health promotion and education.

Further details and enquiries can be directed to E: Indigenous-EyeHealth@unimelb.edu.au or P: +61 3 8344 9320

Indigenous Eye Health at the University of Melbourne have published We are nearly there…Close the Gap for Vision as a 20-page report providing additional detail and this is available with other Indigenous Eye Health resources at www.iehu.edu.au
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<th>Continuation of current funding ~$10m</th>
<th>Additional funding per annum ~$10m</th>
<th>Total funding per annum ~$20m</th>
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</thead>
<tbody>
<tr>
<td>Trachoma</td>
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<td>5.8</td>
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<td>National Oversight</td>
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<tr>
<td>Diabetes/training/equipment</td>
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<td></td>
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<tr>
<td>Jurisdictional coordination</td>
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<tr>
<td>Regional coordination</td>
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<td>Local coordination</td>
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<td><strong>TOTAL</strong></td>
<td></td>
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</tr>
</tbody>
</table>

*Estimated additional annual funds required to Close the Gap for Vision (McKinsey, 2016)*

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**RANZCO 2017**

**CONGRESS COURSES AND SYMPOSIA**

This is your chance to submit an abstract for inclusion in the upcoming Congress; 28 October to 1 November in Perth. Visit the 2017 Congress website before Monday 3 April to submit your abstract! [www.ranzco2017.com](http://www.ranzco2017.com)
A RANZCO Leadership Development Program (LDP) Masterclass, convened by Dr Cathy Green, was held over two-and-a-half days (27-29 January 2017) at Scottish House Business Centre in Melbourne. Participants included members of the RANZCO Board and the Leadership Development Committee and the eight Fellows who are enrolled in the LDP, sponsored by Branches/SIGs.

In the session Getting Your Message Across: Managing Meetings Effectively, Simon Abbott, Training Manager, Allergan ANZ talked about how Insights Discovery’s next generation personality profiling system (based on the work of Carl Jung) can assist in better understanding one’s own communication preferences and better appreciating communication styles that are different from one’s own. Simon illustrated how the ‘colours system’ provides the ability to recognise and adjust one’s own preferred style to collaborate more effectively with others. He then gave practical examples on how to run meetings effectively.

Professor Anne Louise Lytle, Director of Leadership at Monash Business School, spoke on the foundations of negotiation. Her speech was followed by a negotiation simulation exercise and then interactive discussions on the fundamentals of claiming and creating value in negotiations.

A/Prof Mark Daniell talked about leadership in eye care through research, policy formation, advocacy and implementation – sharing his personal experiences as a clinician scientist who ended up being the RANZCO President.

In a session on Mentoring in Academic Professionalism: The Art & Science of Peer-reviewing Papers, Prof David Mackey talked about peer review as an evolving area and the need for ophthalmologists to be involved. David emphasised the importance of training and urged that all in the next generation of ophthalmologists should be good at reviewing the work of others.

Dr David Andrews, RANZCO CEO, spoke about governance in organisations with specific reference to RANZCO, talking about responsibilities of the Board and the committees, volunteering and the difference between management and governance.

Dr Cathy Green, RANZCO Director, presented on working with industry, covering examples of conflicts of interest.

Dr Brad Horsburgh, immediate past President of RANZCO, discussed leadership in difficult times and shared pearls of wisdom garnered during his presidency, channelling Rumsfeld’s known knowns, known unknowns, and unknown unknowns.

Dr Neil Murray, RANZCO Director, and Gerhard Schlenther, General Manager Policy & Programs, facilitated a workshop Doctors with Borders: Volunteerism and Professionalism.
Neil presented his experiences on volunteering in the developing world, reflecting on the boundaries that should be adhered to by those who participate in international activities. He emphasised the importance of the Vision 2020 Right to Sight framework, calling for international development solutions to be integrated, sustainable, equitable and excellent. Participants were then given a scenario to identify red flags from a governance perspective and deliberate in groups on how they may have dealt differently with each of the identified issues.

An afternoon session was devoted to advocacy. Cathy introduced the topic of advocacy which can be described as a planned process of influencing in order to achieve a specific outcome. Neil further explained how the International Agency for the Prevention of Blindness used the evidence (global data on blindness and eye diseases) to influence policy outcomes at the global, regional and national levels. The participants were given a scenario to discuss in groups. After identifying the problem in group deliberations, the groups were asked to develop a set of activities that they would engage in over a given period of time in order to achieve some specific advocacy goals as determined by the groups.

Marsheila Devan, in a session aptly named Communicating with Confidence, explained that “good communication is not a matter of chance, but a matter of choice”. In a very dynamic and energetic session, Marsheila exposed weak points in presentations. Through on-the-spot learning in a fun environment participants learned how to improve their presentation skills.

Dr Christine Younan, reflecting on the value of the RANZCO LDP, advised that, other than being a clinician, there are many ways one can contribute to improve vision. By choosing to be involved in other activities (e.g. Branches, committees, community initiatives, research teams, etc.) and applying new skills learned through the LDP, such as how to be an effective committee chair, how to negotiate with administrators or government, and how to effect change in one’s own working environment, one can grow into numerous other roles.

Gerhard Schlenther, General Manager Policy & Programs RANZCO

COMMENTS ON THE LDP

“Valuable to open your eyes to possibilities of effecting change outside of just being a doctor. Self-growth is never a bad thing.”

“It provides insight into our weaknesses, complements clinical skills well. An area of deficiency.”

“Brilliant learning experience that will truly add to my skills as a leader, both in the long term, and the short term.”

“Need more leaders with confidence to take things on in our state. The program is empowering in that our colleagues are supporting us to be here and are hence more receptive to being led where we want to lead them.”

The RANZCO LDP cohort 2017 with faculty members
The First OCT Item Number in Australia

The eye health and vision care sector has made great advances through the National Eye Health Survey, with the listing of a diabetic photo-screening Medical Benefits Schedule (MBS) item number and the roll out of five million dollars’ worth of screening cameras to Indigenous health centres across Australia.

Item descriptor

### Category 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
### Group D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
### Subgroup 2 - OPHTHALMOLOGY

<table>
<thead>
<tr>
<th>MBS 11219</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optical coherence tomography to determine if the requirements relating to:</td>
</tr>
<tr>
<td>a. age related macular degeneration for access to initial treatment with ranibizumab or aflibercept or</td>
</tr>
<tr>
<td>b. diabetic macular oedema for access to initial treatment with ranibizumab, aflibercept, or dexamethasone, or</td>
</tr>
<tr>
<td>c. central retinal vein occlusion for access to initial treatment with ranibizumab or aflibercept, or</td>
</tr>
<tr>
<td>d. branch retinal vein occlusion for access to initial treatment with ranibizumab</td>
</tr>
<tr>
<td>under the pharmaceutical benefits scheme are fulfilled.</td>
</tr>
<tr>
<td>Maximum of one service in a 12 month period</td>
</tr>
<tr>
<td>Fee: $40.00</td>
</tr>
</tbody>
</table>

Item 11219 will reimburse the use of OCT as an alternative diagnostic procedure to fluorescein angiography to determine patient eligibility requirements for initial treatment with anti-VEGF therapies, including ranibizumab and aflibercept, in age-related macular degeneration, diabetic macular oedema (DMO) and central or branch retinal vein occlusion plus dexamethasone for DMO.

This is great news for patients. OCT is non-invasive and reproducible, requiring neither dye injection nor the bright lights used for fluorescein angiography, so it’s both easier for ophthalmologists to interpret and advantageous for patients. OCT is also very good at measuring thickness of the retina, so it’s helpful in managing treatment for diseases that cause fluid to build-up, which occurs in all the retinal conditions listed in the item number.

Further, the Pharmaceutical Benefits Advisory Committee as of December 2016 has supported the implementation of a recommendation which allows non-ophthalmologist doctors such as registrars to phone the Pharmaceutical Benefits Service to gain authority for restricted drugs under the instruction of an ophthalmologist, once again improving access to these restricted drugs.

### Looking forward

While this is great news for patients who require treatment for diabetes related eye disease, the sector’s work is not complete. To quote Professor Jay S. Duker, Tufts Medical Center, Boston, USA, “in 2016, you can’t manage diabetic macular edema, wet age-related macular degeneration or retinal vein occlusions without an OCT. It’s standard of care for treatment of those diseases.”

The eye health and vision care sector is seeking funding for the placement of additional combined colour fundus and OCT machines in strategic rural and remote centres. It is likely that a combination of fixed and mobile OCT machines will be needed. Such units have proven to be robust in pilot mobile treatment facilities in Queensland and Western Australia.

Every advance in retinal imaging has been accompanied by a greater understanding of disease, leading to better therapy for patients. All Australians rightly expect to have access to great medical advances and Vision 2020 Australia and RANZCO are facilitating this through targeted and expertise-driven advocacy with all levels of government.

**Dr Rowan Porter, MBBS, FRANZCO**
For the concluding edition of our three-part series on collaborative care in diabetic retinopathy, we have spoken with RANZCO Council Member Dr Rowan Porter about his work with the Indigenous Diabetes, Eye and Screening (IDEAS) Van Project in Queensland.

Dr Rowan Porter, a RANZCO Council Member, is a medical retina specialist with a special interest in Indigenous eye health working in both urban and remote centres delivering standard of care services through a range of initiatives. These include the Inala Centre of Excellence in Indigenous Health and the IDEAS Van. He also works in advocacy at a Federal level through the Vision 2020 Australia Aboriginal and Torres Strait Islander Committee.

Dr Porter has a particular interest in Indigenous eye care and dedicates a significant amount of his time to improving the eye health outcomes of Indigenous people in both urban and remote areas. Through the IDEAS Van, Dr Porter seeks to overcome some of the barriers to access to specialist eye care for people in remote areas. Asked about these barriers, Dr Porter explains that there are many factors which make it difficult for people in remote areas, and for Indigenous people especially, to access specialist eye care. These barriers include patient factors, geographical remoteness, workforce issues, institutional barriers and the cost of ophthalmology equipment.

“The significant and complex cultural differences, reflecting the importance of family and cultural activities to Indigenous people, can be a real barrier to accessing care. This is something that RANZCO is seeking to address through the cultural safety training resources which we are developing and which are to become a training requirement,” Dr Porter explained.

In relation to diabetes in particular, Dr Porter explained that diabetic patients can need as much as a month of outpatient appointments in just one calendar year to manage and treat their diabetes. With this many appointments, some appointments, including those needed for eye care, may be missed.

On top of the cultural divide and the profusion of medical appointments, the barriers that come with geographic remoteness make access to specialist eye care even more difficult for Indigenous people in remote areas.
Dr Porter uses the Queensland town of Cherbourg – a community north west of Brisbane – as an example. In Cherbourg, he explains, a patient has to make a seven-hour round trip to get to the public hospital in Brisbane. For people with diabetes who need ongoing medical assessments and treatment, those appointments add up. Even for patients with non-chronic conditions such as cataracts, this is a huge burden.

“A patient with a cataract living in Cherbourg has to make a seven-hour round trip to the public hospital in Brisbane, and they have to do this three or four times, to get just one cataract treated. While half a dozen patients might be referred at one time, the patients are normally transported one at a time. Through regional Indigenous surgery plus pre- and post-operative clinics on the IDEAS Van situated at the Aboriginal Medical Service, we are able to make surgery a community-based activity and reduce transport cost. We can also overcome some of the cultural barriers, allowing patients to celebrate together and provide positive feedback to their communities, getting more people engaged in the idea of better eye care. That is why we are advocating for Indigenous cataract lists, for example.”

Dr Porter goes on to explain that workforce distribution provides another barrier for people in remote areas. Despite Queensland being a very decentralised state and having a majority of people living outside the capital, the majority of ophthalmology work takes place in the south east corner of the state. “There is a big workforce mismatch,” Dr Porter highlighted. “There needs to be a different practitioner funding model for regional and remote Australia to encourage doctors to leave the comforts of the city. Professional and social isolation with a lack of access to the best schooling also contribute to the disparity and this needs to be taken into account.”

With the third highest cost of equipment of all the medical specialties, financial factors are also a barrier to providing ophthalmology services in remote areas. “For this reason,” Dr Porter explained, “equipment needs to be strategically placed at regional hubs, as well as having some shared mobile equipment either on a mobile van or aerial service to reach the smaller communities.”

Finally, Dr Porter explained that there are institutional barriers to accessing care, due to a demarcation between federally funded Indigenous primary care centres and the state facilities where treatments such as cataract surgery are performed. “Poverty factors dictate that the majority of Indigenous people rely almost entirely on public cataract surgery,” he explained. “This highlights the need for a good pathway from the Aboriginal Medical Service health centre to the Queensland health surgical facility at the regional hub. Ideally, the ophthalmologist at the state facility would provide an outreach clinic to the federal facility to enable continuity of care for patients with pre- and post-operative care at the culturally friendly Aboriginal Medical Service.”

The IDEAS Van provides an answer to many of these barriers, providing a community based ophthalmology service that tears down the geographical barriers, bringing the expensive equipment and the eye care specialist directly to people in remote areas of Queensland. The IDEAS Van has been hugely successful. Since it began operating in March 2014, 2,502 patients have been referred to an IDEAS Van clinic for treatment, over 100 patients have received cataract surgery in the Van and 4,227 predominantly diabetes patients from 45 communities have been screened, enabling them to have their annual eye screen in culturally familiar surroundings.

Speaking about the success of the IDEAS Van, Dr Porter said that the robust partnerships with Indigenous health groups and other companies, colleges and interest groups have been essential in delivering success. “All of these organisations working together, with a desire to contribute and gain a sense of ownership of the program, have made the IDEAS Van what it is today. For example, working with local organisations we can ensure that the introduction of the IDEAS Van to the community is done in a culturally appropriate manner. A day is allocated specifically to achieving this culturally appropriate introduction, often involving a smoking ceremony, a welcome to country and a meal together with ophthalmologists. All community elders have the opportunity to inspect the Van and discuss the intentions of the initiative.”

The IDEAS Van enables regional ophthalmologists already working in Indigenous health centres to enhance their service by providing a three room facility with $900k worth of equipment. There is an emphasis on locals working on the IDEAS Van (ophthalmologist, orthoptist and optometrist) to bring continuity of care between Van visits and when surgery is needed at the state facility.

Due to the workforce mismatch some centres do require a city ophthalmologist to fly in one day every month or two, with continuity of care developing as one city practice takes responsibility for one remote clinic. Over the last couple of years, 17 ophthalmologists have volunteered. Dr Porter attributes this high volunteer rate to the fact that the IDEAS Van enables ophthalmologists to provide the same quality of care that they could provide in their city private practice.

Of course, the IDEAS Van is limited in terms of which areas it can get to; it has to travel on bitumen roads, for example. In terms of how people in areas without proper road access get services, Dr Porter points out that, while the IDEAS Van is an icon of the initiative, the screening program has been even more important in terms of reaching the most remote areas. The screening program has provided 27 cameras to 47 communities across Queensland.

“This creates a hub and spoke model of care where the cameras can get to the smallest communities,” explained Dr Porter. “The camera can be fixed or mobile with a chronic disease nurse leaving the camera at one clinic or another for a month at a time. In this way the project can use ‘store and forward’ telehealth to send the images to a grading centre run by Prof Paul Mitchell, where the images are being graded and reported back to the Indigenous health centre.

“This screening data is important, not only for the GPs to better manage a patient’s diabetes but to allow coordinators to know which patients...”
Dr Porter believes that photo-screening has been the missing link to close both the longevity gap and the eye health gap. A large portion of the longevity gap is associated with macrovascular and microvascular complications of diabetes. However, he stressed that it requires accurate grading and coordination of treatment based on the results to achieve a real change in health inequalities.

Currently, only 20% of Indigenous people with diabetes receive the annual photoscreening that is required according to National Health and Medical Research Council guidelines. Dr Porter believes that the new MBS item number, introduced in November 2016 for GPs to undertake photoscreening for diabetic eye disease, will make cameras the first line of eye care regionally with benefits for all involved.

“The growing diabetes epidemic requires those most in need to have access to optometry and ophthalmology treatment,” he explains. “Photos enhance patient education and systemic management of the diabetic microangiopathy by physicians. They also help in triaging patients for optometry and ophthalmology care. The optometrist sorts out those with ungradable images and reduced acuity for glasses and ophthalmology referral. The limited time the ophthalmologist has can thus be devoted to those most in need of treatment, rather than spending time screening.”

Dr Porter cited an example from the Inala Indigenous Health Service. Prior to obtaining a camera for the photoscreening at this centre, screening for diabetic retinopathy was reported to be about 13%. Within 12 months the centre determined that 90% of their eligible diabetic patients were getting diabetic photoscreening.

Looking to the future, Dr Porter sees technology playing an increasingly important role, with cheaper and more portable combined OCT and colour cameras for enhanced screening and better smart phone attachments for fundus photography even in the smallest communities. He expects that there will be greater penetration of smartphones with applications that aid in the monitoring, management and education of patients with diabetes.

“GPs will have access to a national grading centre for ongoing education, quality assurance and patient safety. There will be increased automation at grading centres,” he said. “There will also be regular Indigenous cataract lists, one to four times a year at the regional state facilities, giving communities confidence that they can access timely cataract surgery locally. In some regions mobile surgical facilities could facilitate this, either taking the form of a trailer with mobile surgical equipment rolled into a state facility or a mobile surgical van that can be an annex to the hospital.

“In ten years’ time, we should see a significant reduction in the health inequalities we see in remote and Indigenous communities, with less avoidable blindness and better treatment for all.”

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**RANZCO 2018 CONGRESS SPEAKERS NOMINATIONS NEEDED!**

Focus on Paediatric Eye Health

According to the World Health Organization (WHO), globally one child goes blind every minute. Half-a-million children will have lost their sight by the end of the year. Blind children have a lifetime of increased morbidity ahead of them. In addition, that lifetime can be very short, with up to 60% of blind children dying within one year of becoming blind. Tragically, the majority of these cases could be treated or prevented.

Children’s eye health has been identified as an important and challenging issue across the world. The WHO has identified childhood blindness and genetic eye diseases as priorities for inclusion in the global eye health action plan. The International Agency for Prevention of Blindness (IAPB) also highlights child eye health as a priority.

Similarly, the RANZCO Public Health Committee has plans to focus efforts in 2017 on paediatric ophthalmic eye health for Australia and New Zealand and has put together an action plan aiming to:

• improve RANZCO’s understanding of current issues and trends in the public health aspect of paediatric eye conditions and diseases;
• facilitate discussion within RANZCO among relevant bodies and the wider Fellowship about paediatric eye health and advocacy needs of both the Fellowship and the wider community;
• articulate RANZCO policy and strategy goals in relation to paediatric eye health and plan appropriate advocacy initiatives;
• increase RANZCO’s collaboration with external bodies on paediatric eye health advocacy;
• increase public awareness of relevant paediatric eye health issues, and;

• improve paediatric eye health practice/outcomes using advocacy guided by the articulated policy and strategy goals.

In his keynote lecture at the 2015 RANZCO Congress, Childhood Vision Impairment: Helping Children See the Future, Associate Professor John Grigg highlighted the magnitude of the problem: 3% of the blind population are children however they have a lifetime of blindness ahead of them. The number of blind-person-years resulting from blindness starting in childhood is second only to cataract from all ages, with genetic eye diseases being the leading cause of blindness in children. Childhood eye health issues have substantial health system, financial and morbidity impacts.

The 2016 release of the Open Eyes: Socioeconomic impact of low vision and blindness from paediatric eye disease report reveals important insights into childhood blindness. In a RANZCO interview, A/Prof Grigg explained what drove the need for such a report.

“It came from recognition for the need to try to improve children’s eye health in two main areas:

• Early identification: early identification will help with treatment because children’s visual systems have a finite development time so we need to be able to identify conditions early.
• Chronic eye diseases: children with chronic eye diseases have a significant life-long impact.

One of the things that set off this process was trying to understand the number of children who had vision impairment, and the impact over their lifetime. We have known for a long time that, for children with refractive error or strabismus or so forth, if you can intervene early you can achieve a normal outcome. This has been the focus of screening programs around the starting age of school.”

A/Prof Grigg found that in Australia and New Zealand there is a well-defined screening program at around six-weeks of age. At the time the child is born, and before they leave the hospital, there is a reflex check looking for major eye anomalies. This is redone at six weeks of age, looking for children’s cataract or potential other ocular problems. It also provides for early identification for these conditions facilitating timely intervention.

The next screening time-point is just prior to school entry. While there is some variation across Australia with each state set up slightly differently, in New South Wales it is called the StEPS (Statewide Eyesight Preschooler Screening) program. Through StEPS all children in pre-school will have their vision screened once they turn four. If their vision is sub-normal in its criteria [less than 6/18 or less than 6/9 in either eye] then they are referred on for assessment and are considered in a priority group with quicker access to the system than a more regular routine appointment. Any child failing this test is given a letter for referral to their own ophthalmologist, optometrist or one of the clinics in the (eye unit) teaching hospitals. This program covers about 90,000 four-year olds with take up of around 70,000 children.
Each state has some sort of screening program but it is not considered as comprehensive as the program in New South Wales. The StEPS program, developed in consultation with paediatric ophthalmologists in New South Wales, initially replaced a system of eye screening performed in kindergarten based on local health districts and socio-economic criteria. Naturally eye problems don’t respect socio-economic boundaries and it is important to identify them as early as possible. In particular with strabismus and refractive error, the age of four is when intervention is most effective because the visual system is developing at its most rapid at this time. This is a critical screening time point and why screening programs target preschoolers as the visual system is most responsive to therapy and there is time to correct problems prior to commencing school.

A/Prof Grigg notes that the StEPS program is probably one of the world’s best screening programs, and needs reinforcement to continue, commenting that the successful components of the StEPS program should be taken to reinforce screening programs in other states.

Moving on to more serious eye conditions, while they are slightly more rare, they have a lifetime impact. In Australia about 1,600 children are diagnosed with visual impairment each year. Whereas looking at the people with cancer it is around about four or five hundred. About three times as many children have vision impairment. The advance in children’s cancer research means that about 90% of those children survive and live a fairly normal life. Whereas currently for chronic eye diseases there are no such treatments and children face a life of vision impairment or blindness.

### Children’s Eye Health - Magnitude: Prevalence Paediatric Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hayfever and allergic rhinitis</td>
<td>9.51</td>
</tr>
<tr>
<td>Asthma</td>
<td>9.34</td>
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<tr>
<td>Long sighted/hyperopia</td>
<td>4.88</td>
</tr>
<tr>
<td>Short sighted/myopia</td>
<td>4.22</td>
</tr>
<tr>
<td>Allergy (undefined)</td>
<td>3.37</td>
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<tr>
<td>Dermatitis and eczema</td>
<td>3.08</td>
</tr>
<tr>
<td>Chronic sinusitis</td>
<td>2.88</td>
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<tr>
<td>Behavioural/emotional problems childhood onset</td>
<td>2.39</td>
</tr>
<tr>
<td>Astigmatism</td>
<td>1.77</td>
</tr>
<tr>
<td>Problems of psychological development</td>
<td>1.47</td>
</tr>
<tr>
<td>Ocular motility (Strabismus)</td>
<td>1.24</td>
</tr>
<tr>
<td>Visual disturbances (Ambyopia, CVI,ONH, OA)</td>
<td>0.96</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0.72</td>
</tr>
<tr>
<td>Eye and adnexa (Cataract, keratitis, uveitis, trauma)</td>
<td>0.16</td>
</tr>
<tr>
<td>Other nervous system (cerebral Palsy)</td>
<td>0.16</td>
</tr>
<tr>
<td>Choroid and retinal (Retinal Dystrophies)</td>
<td>0.15</td>
</tr>
<tr>
<td>Endocrine, metabolic diseases (Cystic Fibrosis)</td>
<td>0.13</td>
</tr>
<tr>
<td>All cancers (5 year prevalence)</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Source: Australian Institute of Health and Welfare. The Australian Health Survey (ABS, 2012)
In terms of the *Open Eyes* report, this was essentially one of the starting points - to try and work out how many of these children have vision impairment, and the economic cost of that. But more so to try to find treatments for children with vision impairment or blindness, as has been done in the children's cancer arena. A/Prof Grigg highlights further that 8 to 10% of the top 500 rare disorders are actually eye conditions and these all affect children (starting in childhood). When you add them together you have a significant number. This has a lifetime effect, impacting initially on education and posing challenges with employment and ongoing health issues, not to mention the extra care required for children and later in adulthood.

### Rare eye disorders selected from top 500

<table>
<thead>
<tr>
<th>ORDER</th>
<th>DISEASE OR GROUP OF DISEASES</th>
<th>ESTIMATED PREVALENCE (/100,000)</th>
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<tr>
<td>2</td>
<td>Ventricular septal defect</td>
<td>272.0</td>
</tr>
<tr>
<td>7</td>
<td>Cleft palate</td>
<td>53.6</td>
</tr>
<tr>
<td>9</td>
<td>Patent arterial duct</td>
<td>50.0</td>
</tr>
<tr>
<td>13</td>
<td>Renal agenesis, unilateral</td>
<td>50.0</td>
</tr>
<tr>
<td>16</td>
<td>Craniosynostosis</td>
<td>45.0</td>
</tr>
<tr>
<td>17</td>
<td>Preeclampsia</td>
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</tr>
<tr>
<td>26</td>
<td>Familial long QT syndrome</td>
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<tr>
<td>33</td>
<td>Uveitis</td>
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<tr>
<td>47</td>
<td>Neurofibromatosis type 1</td>
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<tr>
<td>51</td>
<td>Vernal keratoconjunctivitis</td>
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<tr>
<td>63</td>
<td>Retinitis pigmentosa</td>
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<td>75</td>
<td>Neovascular glaucoma</td>
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<tr>
<td>92</td>
<td>Oligoarticular juvenile arthritis</td>
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<td>125</td>
<td>Marfan syndrome</td>
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<tr>
<td>126</td>
<td>Sickle cell anemia</td>
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<td>132</td>
<td>Atopic keratoconjunctivitis</td>
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<td>145</td>
<td>Sarcoïdosis</td>
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<td>164</td>
<td>Stargardt disease</td>
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<tr>
<td>166</td>
<td>Linear nevus sebaceous syndrome</td>
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<tr>
<td>167</td>
<td>Phenylketonuria</td>
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<tr>
<td>169</td>
<td>Tuberous sclerosis</td>
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<tr>
<td>172</td>
<td>Duane retraction syndrome</td>
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<tr>
<td>173</td>
<td>Septo-optic dysplasia</td>
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<tr>
<td>196</td>
<td>Anophthalmia - microphthalmia</td>
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<tr>
<td>203</td>
<td>Ocular coloboma</td>
<td>8.0</td>
</tr>
<tr>
<td>214</td>
<td>Cystic fibrosis</td>
<td>7.4</td>
</tr>
<tr>
<td>234</td>
<td>CHARGE syndrome</td>
<td>6.5</td>
</tr>
<tr>
<td>240</td>
<td>Retinoblastoma</td>
<td>6.0</td>
</tr>
<tr>
<td>248</td>
<td>Oculocutaneous albinism</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Source: Grigg, J. *Childhood Vision Impairment: Helping Children See the Future.* 2015 RANZCO Congress.
Many of the diseases are genetically based which we need to understand better. Each condition may be rare but when added together they affect over 8% of the population. Rare disorders make up about 70% of the work focus in children’s hospitals. In children the time pressures can be more significant because if you don’t get the disease treated the visual system can’t develop normally. Even if you fix the disease the visual will remain impaired. The real challenge in paediatric eye disease is that you’ve got a developing visual system that won’t be able to develop to its full potential if the eye disease is not fixed.

The significance of the Open Eyes report crosses three areas: early detection for all conditions, early detection for treatable eye conditions, and early detection for those with untreatable eye conditions who can then get early and appropriate support services. The data collected about this also helps us to advocate for research funding to alleviate lifelong blindness.

**Insights revealed from the Open Eyes report**

- **Refractive error** (hyperopia, myopia and astigmatism) accounts for three of the top ten most common long-term health conditions in under 15 year olds.

- Other **ocular disorders** and **visual disturbances** are more common than many other childhood conditions such as epilepsy, cerebral palsy, cystic fibrosis and childhood cancer.

- In 2015 there were almost a **third of a million** Australian children with vision impairment or the potential to become visually impaired.

- **$439M**
  In 2015 the total health costs to treat children with diseases of the eye and adnexa were an estimated **$439 million**, or 11.3% of the total health system expenditure on eye conditions.

- **$50M**
  Having a vision impairment causing disability reduces the chance of being employed by almost 50%.

- **$624M**
  The estimated economic impact of vision impairment in children is **$624 million** per year.

- **$1.31B**
  Today’s 17 year olds can expect their lifetime real earnings to be **$53,916** lower than that of their colleagues without vision impairment.

- **$1.31B**
  The total cost of disability adjusted life years amounts to **$1.31 billion**, or $3,880 per child with VI in 2015.

**Reference:**
Associate Professor Grigg is a world renowned paediatric ophthalmologist and Head of Discipline at the University of Sydney’s Discipline of Clinical Ophthalmology and Eye Health. He also consults at Sydney Eye Hospital and the Children’s Hospital Westmead.

A/Prof Grigg is Head of the Discipline of Ophthalmology at The University of Sydney’s Save Sight Institute.

He completed ophthalmology training on the Sydney Eye Hospital program and undertook fellowships in glaucoma, paediatric ophthalmology and visual electrophysiology in Australia and the UK.

He has clinical responsibilities at Sydney Eye Hospital including glaucoma and inherited eye disease clinics, as well as at The Children’s Hospital, Westmead, Sydney. This includes leading the clinical visual electrophysiology service at Sydney Eye Hospital and Children’s Hospital Westmead.

He is a member of the eye genetics research group Save Sight Institute, Children’s Medical Research Institute and Children’s Hospital Westmead. His main areas of research are in genetic eye disease and electrophysiology of the visual system and glaucoma management.

A/Prof Grigg has authored numerous publications and textbook chapters on glaucoma and paediatric eye disease. In 2013 he co-chaired the World Glaucoma Association’s consensus statement on paediatric glaucoma. A/Prof Grigg chaired RANZCO’s Scientific Programme Committee from 2009-12 and was Paediatric Ophthalmology section editor of Clinical and Experimental Ophthalmology from 1997 to 2008.

He has been the Postgraduate coursework coordinator for the Discipline of Ophthalmology since 2008. During this time he has overseen the expansion of the postgraduate program run in conjunction with Otago University. 70% of all RANZCO trainees have completed a unit of study in the program.

A/Prof Grigg’s research interests are paediatric eye disease, genetic eye disease, glaucoma, ocular electrophysiology and laser assisted cataract surgery.

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**Eye Health Case Studies**

A key project focus area for the **RANZCO Public Health Committee** this year is **Paediatric Eye Health**.

We are interested in hearing from and working with Fellows who have case studies from a public health perspective that can help inform public health awareness creation activities and strategies for 2017.

We are looking to build a number of potential key messages/areas to explore, for example:

- If you think your child has an eye problem don’t delay getting an eye check, it’s never too early.
- If your child has a ‘funny’ eye get it checked, it might be something serious.
- Healthy habits in pregnancy build healthy babies with healthy eyes.
- Young children won’t tell you they can’t see. If in doubt, get their vision checked by an eye specialist.

If you have a story to share or can offer some expertise in this area Please contact Gail van Heerden, Project and Policy Officer on E: gvanheerden@ranzco.edu or T: +61 2 9690 1001.
International Development

RANZCO Congress Scholarship Program contributing to the Asia-Pacific region

In 2016, four RANZCO International Scholarship recipients attended the College Annual Scientific Congress in Melbourne. Scholarship recipients also attended the advocacy themed International Development Workshop held prior to the Congress. We are pleased to be sharing the following feedback on their experience.

| Scholarship Recipient | Scholarship attendance feedback                                                                                                                                                                                                                                                                                                                                                       | Presentation topic at the RANZCO International Development Workshop                                                                                             |
|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Ly Marina             | • “I gained a lot of information related to medical knowledge which is relevant to my clinical work and management lessons in eye care such as in the International Development Workshop which talked about the advocacy activities.”                                                                                                                |
|                       | • “I could bring this useful information to my juniors as well as my colleagues to motivate them to find something new and interesting for each annual congress in my country.”                                                                                                                                       |
|                       | • “I was really interested in the retina sessions. I found these to be very active sessions. There were many discussions during the presentations. Also the speakers present updated information to the audience. It is really different from my country – sometimes we only focus on literature reviews and case studies or some other available information. It is not like here where we can learn a lot of new things.” | Establishment of First Continuing Professional Development in Cambodia                                                                                         |
|                       |                                                                                                                                                                                                                                                                                                                                                                                   | Understanding barriers and components needed for successful implementation of effective CPD in Cambodia                                              |
| Kham Od Nouansavanh | “The International Development Workshop was powerful; the first thing I learnt was what the workshop is and how to process the workshop - I have never attended one before. The second thing was to learn about what one should do when faced with issues and how to identify the problems and how to deal with them, who else should be involved, and how to help each other in solving them.” |
| Laos | “I gained a lot of knowledge, for example, during the workshop there were many experts who have a long experience in dealing with problems especially in developing countries. I can apply this knowledge in my own practice as well as in working together with other organisations in the eye health care sector.” |
| | “I really appreciate that RANZCO provided me with this scholarship and gave me the opportunity to do and learn many new things such as giving a presentation in English for the first time. Also, to join the elegant Congress dinner and to see the beautiful city of Melbourne. I had the chance to meet new people, to network and to expand my vision.” |
| Jambi Garap | “Appreciated the participation required at the International Development Workshop. For me the highlight was to be given a platform to present on Trachoma in Papua New Guinea (PNG) and to talk about all that is happening in PNG. There are a lot of things happening in my country that people don’t realise.” |
| Papua New Guinea | “From the advocacy point of view, it has been an eye opener with all the [advocacy] techniques that have been used. Brainstorming through all causes and effects and the process to getting to the final answer is always interesting to see. Another highlight for me from the workshop was Prof Hugh Taylor’s presentation where he mentioned that ‘if you want to see a change in your program you have to be present. Your presence shows that you are committed.’” |
| | “In terms of the main plenary sessions, I was interested in cornea and new techniques of treating cornea and the idea of 3D printing in finding a solution.” |
| Geoffrey Wabulembo | “I was very grateful to be able to present on eye care in Uganda as it gave me the opportunity to reflect on what I had gone through in previous years. Now I am able to actually draw on some lessons from the International Development Workshop and apply these in my current position as Senior Lecturer at the University of Papua New Guinea.” |
| Papua New Guinea | “My favourite lecture from Congress was the one on ‘Complicated Cataract Surgery: How can we Calm the Troubled Waters?’ I think all ophthalmologists who are operating on cataracts have a story to tell about troubled waters.” |
| | “In the developing countries there is an aspiration, for example, to perform Phaco even though small incision cataract surgery is going well. But, from the papers presented at Congress, comparing the outcome of these two procedures, I realised that the evidence is favourable for both. I think as professionals in developing countries we can look forward to doing Phaco, but if it is not available we should also be happy with small incision cataract surgery.” |
Scholarship Feedback

I will follow up contacts I made at RANZCO Congress
It gave me ideas that I can implement in my practice
I found it valuable to attend the trade exhibition
It improved my knowledge of practice management issues
It improved my knowledge of clinical issues
It improved my knowledge of scientific issues
The congress met my expectations
The International Development Workshop met my expectations

Dr Geoffrey Wabulembo’s take-home messages from the RANZCO Congress:
• Be sure to use local capacity as much as possible.
• Incorporate research in the work that is going on.
• Mentor somebody in order to grow the profession.
• Collaborative efforts should be undertaken by all stakeholders.
• In planning ask the people what they want. It may be different from what you plan for them.

The RANZCO International Scholarship Program, overseen by the International Development Committee (IDC), is aimed at developing eye care education and professional standards in support of the Vision 2020: Right to Sight initiative that seeks to eliminate avoidable blindness and vision impairment by 2020. To ensure a meaningful engagement in the Asia-Pacific region, RANZCO seeks to link the scholarships program with operational education and training activities in developing countries. Every year the IDC reviews eligibility and prioritises countries based on education and training projects run by the College and opportunities that may arise through our engagement with Vision 2020 Global Committee members.
In December 2016, RANZCO Fellows Drs Mark Renehan and David Moran, and Prof Prut Hanutsaha from Thailand, assisted by Craig Dowling, RANZCO General Manager Trainees and Examinations, participated in the final Ophthalmology Residency Training (ORT) examination at the University of Health Sciences (UHS) in Phnom Penh, Cambodia. Participation of external examiners enabled the promotion of capacity building among faculty and the strengthening of the teaching and learning environment by identifying any gaps in the process and making recommendations and by attesting a fair and standardised examination process.

This activity follows over a decade of collaboration between RANZCO and the UHS, in collaboration with Fred Hollows Foundation in Phnom Penh. The previous three to four years focussed intensively on building capacity of local faculty and alignment of teaching and assessment with a new curriculum through a series of workshops on contemporary clinical teaching and assessment practice. External examiners were able to support and embed the assessment techniques introduced as part of the new curriculum.

Twenty-one residents presented for the written examinations with ten year-two and year-three residents presenting for the Objective Structured Clinical Examination (OSCE), and five year-three residents presenting for the oral examination. This was the second time that the OSCE was administered as part of the ORT. The focus in 2016 was to move to more of an autonomously run OSCE with RANZCO supporting and guiding the ORT administrator and the exam assistants in the finalisation, preparation and administration of the OSCE.

Led by Prof Ngy Meng, Cambodia National Program for Eye Health Chairman, and ORT Training Coordinator, an informative and useful post ORT examination wrap up session was held with faculty, external examiners and the supporting team following the conclusion of the examination. Dr Renehan commended the ORT faculty on a successful examination, noting the great input and enthusiasm from all involved.

With the expectation that the intake of year-one residents in 2017 will increase substantially, ORT faculty already engaged in discussion (during the wrap up meeting) of the possibility of increasing OSCE stations and streamlining the administration of the year-end examinations by moving more of the assessment components online. The continuation of multiple choice question preparation and planning throughout the year would also free up faculty and examiner time to focus on finalising papers and examination assessment come the year end.

Dr Renehan reiterated that the collaboration with UHS has been a good investment and looks forward to RANZCO’s continued involvement and support of ophthalmology in Cambodia, “RANZCO involvement in the capacity not only helped ophthalmic training but all the other training areas taking leadership – in that other specialties are following the lead of ophthalmology and introducing the same principles in terms of curriculum development.”
DAME IDA MANN - 1893-1983

Graduating in medicine, Ida Mann subsequently published a DSc thesis on the development of the human eye. This was soon followed by congenital defects of the eye in 1937. Both of these publications were trail blazing and definitive texts of embryology.

Ida’s wide interests included comparative anatomy. She established the first contact lens clinic in London prior to the First World War and researched mustard gas keratitis and thyroid eye disease.

Appointed as Assistant Surgeon to the Central London Hospital, Ida became the first female consultant to the Royal London Ophthalmic Hospital, later known as Moorfields. She was subsequently appointed as Senior Surgeon.

Oxford University appointed her Margaret Ogilvie’s reader in ophthalmology and she subsequently gained a personal chair, which was the first in Britain for a woman to hold the title of professor at Oxford.

She was honoured with the Doyne lecture in 1928 and the Harrison Gale lecture in 1929. Other notable lectures were the Nettleship medal and the Montgomery lecture in 1935.

In 1949 her husband Bill Gye, a cancer researcher, became ill and they both travelled to Australia to escape the bleak climate of post war Britain. They settled in Perth, with her husband continuing his research into viruses and cancer. Ida set up an ophthalmic practice with her original Gullstrand slit lamp, which was eventually passed on to Andrew Stewart, Past President of RANZCO.

Ida met up with Father Frank Flynn, a Catholic priest and ophthalmologist who had been Ida’s House Surgeon at Moorfields some 20 years earlier. He introduced her to trachoma, something she had not encountered in the United Kingdom. This led to an investigation, lasting four years, documenting the cause of the high rate of blindness among the Aboriginal population of the Kimberley and Western Desert. This highlighted the prevalence of a disease ignored by governments in Australia.

Ida travelled incessantly over the next 20 years in outback Western Australia, between times maintaining her small city practice in Dalkeith and the coastal town of Busselton until her retirement in 1976.

Ida was honoured for her many contributions to ophthalmology, becoming a Commander of the British Empire (CBE) in 1950 and Dame (DBE) in 1980.
The molecular biography of John Dalton

Kocak ED1, Wang BZ2, Kaufman DV3
1Department of Ophthalmology, The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, Australia; 2The Royal Australian and New Zealand College of Ophthalmologists

Background
John Dalton's contribution to the theory and molecular makeup of colour blindness has continued well beyond his last published work in the nineteenth century. We review his original theories and recent developments.

John Dalton
6 Sep 1766 – 27 Jul 1844
John Dalton was a celebrated chemist, scientist and meteorologist most well known for his physics theories:
• Dalton's Law of Partial Pressures
  \[ P_{\text{total}} = P_1 + P_2 + P_3 + \ldots \]
• Atomic Theory

Observations on colour blindness
In 1794, John Dalton described his own colour blindness in a lecture to the Manchester Literary and Philosophical Society. Red sealing wax appeared nearly identical to the leaf of the English laurel (Prunus laurocerasus). The pink flower of the cranesbill (Pelargonium zonale) appeared sky blue in the daylight, but red by candle-light. Dalton distinguished only two kinds of hue:
• Yellow, corresponding to the normal person's red, orange, yellow, and green
• Blue, corresponding to blue and purple

An inherited anomaly
Dalton observed similar colour deficiency in up to 20 family members and friends, including his brother. Colour blindness only seemed to occur in males, the first clue of a sex-linked inheritance.

Post-mortem
Dalton proposed the distortion of colour was due to a blue-tinted vitreous.1 His foresight to preserve his own eyes following his death resulted in his theory being disproven. Post-mortem examination by his assistant, Joseph Ransome, found his vitreous to be perfectly clear.2 Ransome left the other eye intact, removed the posterior pole and observed that red or green objects were not distorted when viewed through the eye. Ransome proposed Dalton's colour blindness arose from a cortical defect. George Palmer later proposed three types of molecule in the retina.3 Thomas Young postulated Dalton's colour blindness arose from a lack of 'fibres of the retina, which are calculated to perceive red'; what is now known as protanopia.4

DNA from a shrivelled eye has the right gene
Dalton's eyes remained preserved until samples were taken in 1995 for DNA analysis. PCR showed that Dalton lacked the middle wave length (530 nm) cone opsin gene, corresponding to deuteranopia and matching his historical descriptions of colour defect.5

References

The molecular biography of John Dalton was the winner of the Jim Martin prize for the Best Historical Poster at the 2016 RANZCO Annual Scientific Congress in Melbourne. Produced by Enis Kocak, an Alfred Hospital resident, it describes the extraordinary observations of scientist John Dalton on colour vision.

To read in more detail, visit the RANZCO Museum website and click on 'Presentations' for information on Ida Mann and John Dalton.

New Acquisitions
New acquisitions for the RANZCO Museum include a unique radio interview of Dr Hugh Ryan in 1948 with recollections of early contact lens use at Moorfields and the quaint but brutal examination system in the UK at that time.

The interview is under ‘memories’ on the RANZCO Museum website (www.ranzco.edu/museum)
What is diversity and inclusion and why does it matter?

Defining the words diversity and inclusion is relatively simple. Diversity means “a range of different things”; inclusion means “including or being included within a group or structure”. However, the concept of diversity and inclusion is more complex than the sum of the two words.

RANZCO’s membership includes people of different genders, races, religions, ideologies, sexualities, etc. While RANZCO is an organisation that includes a diverse range of people, the missing perspective is whether each of these people feel that they and their differences are as accepted and included as everyone else. This is the concept of inclusion, and this is what we are working to achieve.

One barrier to this can be the idea of everybody being treated the same. As a concept, this sounds like the right thing to do: “I was treated this way and I was perfectly happy with it, therefore I will treat this person that way and they, too, should be perfectly happy with it.” The problem is that one size does not necessarily fit all and by failing to understand that we risk making some people feel less included, less valued, than others.

One analogy about this is the concept of a business built by giraffes! This giraffe business would have tall thin doors, narrow chairs and computer screens placed high up on the wall. But the giraffe business exists in a world in which all sorts of employees exist, including, for example, elephants. An elephant employee of that business would be unable to fit through the doors or into the chairs. If he did manage to get in he would find himself unable to see the computer screen, which would be far too high on the wall for him. He would be unable to do his job as well as the giraffe, who could see the screen perfectly well. A couple of years down the line, the giraffes employed at the business have all been performing brilliantly and have had promotions. The elephants, meanwhile, have struggled to fit in their chairs, and have had to climb ladders to see their computer screens. Their work has suffered and they haven’t been performing to their full potential. Very few of the elephants have been promoted. Now, you have a business in which all of the management are giraffes and they make the decisions for the junior staff, never noticing that the junior staff just need bigger doorways, wider chairs and lower computer screens. Meanwhile, the business down the street has doors that are wide enough for elephants and tall enough for giraffes. It has adjustable computers screens so that everyone can see equally well. Everybody wants to work there, because they know that they are appreciated and can work to their full potential. Before long, the inclusive business has the best, most motivated and happiest staff, and it is vastly out-performing the non-inclusive giraffe business.

The idea of diversity and inclusion, therefore, is to design a business that works for everyone, despite their differences, rather than to expect an elephant to make himself as tall and slim as a giraffe just to fit in. And the benefit of this is seen by the business as a whole, not just by the individuals.

With our focus on diversity and inclusion, RANZCO is seeking to ensure that all of our members feel equally accepted, valued for their contribution and included both within RANZCO as an organisation and within their own training and working environments.

One organisation, two nations

RANZCO, like all collectives, does not exist in a vacuum and is a reflection of the cultures it exists in as well as the cultures which exist within it. Australia and New Zealand are, for all their similarities, quite different countries and have embraced diversity and inclusion to differing degrees. Add to this the fact that the training of RANZCO Fellows primarily occurs at hospital sites, and then the practice of ophthalmology occurs in numerous settings (private practice, day surgery, rural and remote areas, overseas) and you have an enormous number of variables that impact on
RANZCO’s own culture. Each Fellow, trainee (and potential trainee) and Associate of the College has their own unique identity and we need to create a culture that moves beyond tolerance of difference to one that enables everyone to feel safe, accepted and included.

**Benefits of Diversity and Inclusion**

It is important to invest in diversity and inclusion not only because it is the right thing to do, but also research shows us that inclusive environments improve job and/ or team performance. It is in the interests of ophthalmology as a profession, and therefore the interests of ophthalmologists’ patients, to increase inclusion for everyone.

Research shows that embracing diversity and inclusion is the best way to overcome the challenges that face us now and in the future. Teams with inclusive climates have higher levels of innovation and inclusive leadership is associated with greater creativity, improved innovation and better complex decision making.

The business case for diversity and inclusion is well established and is laid out on the Diversity Council of Australia’s website at [www.dca.org.au/capitalisingonculture](http://www.dca.org.au/capitalisingonculture).

In addition to the obvious general business case reasons for embracing diversity and inclusion, there are more specific reasons that RANZCO must meet this challenge head on.

**AMC Accreditation in Australia**

The Australian Medical Council standards address the provision of high quality medical specialist education and training in Australia and New Zealand. From a diversity and inclusion perspective RANZCO is committed to uphold the following:

1. That the central tenet of all medical education is patient safety and there is an expectation that education providers address health disparities by increasing the cultural competence. As such, RANZCO’s training curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia and Māori health, history and cultures in New Zealand. Moreover, cultural competency is carried through to post-vocational education through resources available on the RANZCO website, which attract CPD points.

2. The development of inclusive practices so that the medical workforce reflects the wider population through outreach programs to recruit trainees from Indigenous backgrounds. To this end, RANZCO is working on ways to increase recruitment and selection of Aboriginal, Torres Strait Islander, Māori and Pasifika trainees.

**Direct linkage to reducing the instances of bullying, harassment and discrimination**

Any organisation that truly embraces diversity and supports diversity and inclusion would, by definition, exclude behaviors that are discriminatory. Accepting each person for who they are means not discriminating and also not bullying. Moreover, respectful organisations are ones comprised of individuals who respect each other, not individuals who take advantage of others through sexual or other harassment. Bad practice affects some people more greatly than others. Good practice benefits everyone.

**It’s not just the right thing to do, it’s the law**

Australia and New Zealand are diverse nations. It is commonly accepted that discriminating against others is wrong and, in many cases, it is illegal. The Committee knows of no valid rationale for excluding a group of individuals based on their race, religion, gender, sexual orientation etc.

What’s the Diversity and Inclusion Committee doing?

The Diversity and Inclusion Committee, as well as a range of other committees, the Board and RANZCO staff, are working towards a coordinated approach across the College. Some initiatives underway at the moment include:

- **VTP:** Assessment of all training sites’ HR policies with regard to bullying, harassment and discrimination. This will have the dual goal of identifying examples of best practice and useful resources and also ensuring that the practices of all training meet national quality standards. We need to ensure all trainees and trainers are being supported at their place of work, by their place of work, and by RANZCO. In addition, we’re working to ensure all training sites have clear policies and services around making complaints and reporting issues. You can come directly to RANZCO with any concerns you might have, or confidentially access the free Employee Assistance Program, which offers support and counselling over the phone.

- **Congress:** Increasing awareness of the nomination and submission processes to ensure a good cross-section of nominated speakers and courses/symposia.

- **CPD:** Making Level 2 CPD points more accessible to Fellows, recognising that certain cohorts of the Fellowship struggle to find the means to carry out certain activities.

- **Determining who we are:** Collecting better data about our own membership shows us how diverse we really are. Benchmarked against the wider population, we can see if RANZCO is reflective of the wider population. If we’re not, we need to ask why not. Could it be that we’re inadvertently discriminating against certain groups of people?

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**Our Vision** - Create an environment within RANZCO that embraces diversity. The College is committed to fostering a culture of inclusiveness where all individuals are respected, and are treated fairly, feel like they belong and can thrive.
We need you!
You will note that the College is striving to provide more readily available statistics on gender diversity with regard to leadership roles. It is hoped that increasing transparency around these statistics will result in more discussion of them and encourage more female Fellows and trainees to apply for available positions. If you’d like to be more involved with the College through a committee, Branch or Working Group or by serving as a College representative on an external body, please keep an eye out for the Calls for Expressions of Interest that are often included in the fortnightly e-news. You can also approach your Branch through the Chairs, listed below, or via the College. Further, the Younger Fellows Advisory Group, Women in Ophthalmology Advisory Group and Senior and Retired Fellows Group are always keen for additional input and support from the Fellows. These groups can be contacted via the College. The Younger Fellows and Senior and Retired Fellows are represented on the Diversity and Inclusion Committee through their respective Chairs.

QLD Branch: qldbranch@ranzco.edu
NSW Branch: nswbranch@ranzco.edu
VIC Branch: vicbranch@ranzco.edu
TAS Branch: tasbranch@ranzco.edu
SA Branch: sabranch@ranzco.edu
WA Branch: wabranch@ranzco.edu
NZ Branch: nzbranch@ranzco.edu

Younger Fellows, Senior and Retired Fellows, Women in Ophthalmology and the Diversity and Inclusion Committee can all be reached by emailing ranzco@ranzco.edu with attention to the relevant group.

RANZCO’s Employee Assistance Program (EAP) is a free, confidential support line available to all RANZCO staff and members and their immediate families: 1300 687 327 (1300 OUR EAP).

Dr Justin Mora

Dr Justin Mora is RANZCO’s first Censor-in-Chief from New Zealand. This position is a standing position of the RANZCO Diversity and Inclusion Committee.

Q What is the Te Tiriti o Waitangi (Treaty of Waitangi) and what does it mean for New Zealanders?
A The Treaty of 1840 is New Zealand’s founding document, in a sense the equivalent of the US Declaration of Independence. It was an agreement between Queen Victoria and the chiefs of the Māori tribes of Aotearoa and it provided for Māori to accept the sovereignty of the Crown in return for specific rights. Unfortunately, those rights were largely ignored for 130 years and it was only in the 1970s, when Māori began to protest more effectively, that the government started to pay attention.
A tribunal was set up to hear the claim of any tribe that had suffered injustices and to recommend redress. Over that last 40 years numerous tribes have received acknowledgement of the wrong done to them, an apology from the Crown and a substantial enough settlement that they have become major contributors to the economy and to the welfare of their own people. While this remains a work in progress there is a lot of pride in New Zealand that we are trying to right past wrongs and the Treaty of Waitangi is the guiding document in that process.

Q What are the major differences in the training sites in New Zealand compared to Australia?
A As of 2017 New Zealand has a single national scheme focused around five major centres and five provincial ones. Most trainees will spend two six-month terms in a provincial post where they will be on their own. Even the major centres are small by Australian standards with the largest, Greenlane in Auckland, having seven trainees. But really there are more similarities than differences in training between the two countries.

Q What are you and the various education committees and RANZCO staff doing to foster a more diverse and inclusive culture in the training program?
A Like other areas of the College, we have a goal of achieving 35%
female representation on the education committees. We have our first female RACE Chair in Dr Maria Moon. The RACE board includes subspecialists and generalists and a mix of urban and provincial representatives. We are looking at how we can increase the number of people from rural backgrounds in the training program and we are determined to increase the number of Māori, Pasifika and Aboriginal and Torres Strait Islanders in ophthalmology. We are working with employing hospitals to make it easier for those wishing to undertake part-time or interrupted training. To counter any potential bias, the CVs of applicants to the training scheme are, from this year, going to be de-identified in terms of name, gender and age.

Q Why is diversity and inclusion important to you?

A I don’t want to make this New Zealand centric, and I acknowledge that like anywhere we have our share of highly conservative people, but I think acceptance of diversity is a strong part of the Kiwi psyche. We are proud that we were the first country in the world to give women the right to vote in 1893 (though Australia wasn’t far behind in 1899). More recently New Zealanders voted to allow gay marriage and while I understand that people have differing views on this I believe it is another example of Kiwis’ willingness to celebrate diversity.

I was a university student at the time of homosexual law reform in NZ and it was a big issue. I remember being affronted that some in our parliament wanted to persist with an outdated law that judged people by their sexuality, but the stronger voices of tolerance won and homosexuality was no longer illegal after 1986. I also recall when, in 1994, during my glaucoma fellowship in San Francisco (a liberal place you would think), a decades-old law came before the state legislature to be reversed. It was a law that outlawed women breastfeeding their babies in public and unbelievably the reversal failed! While that has since changed there are still several US states that fail to protect a mother’s right to nurse her baby.

But beyond all those personal factors, we must remember that our College represents the interests of everyone in Australia and New Zealand and the diversity of our organisation should match the diversity of our societies. And, of course, it is well proven that more diverse organisations perform better.

Equality Versus Equity

In the first image, it is assumed that everyone will benefit from the same supports. They are being treated equally.

In the second image, individuals are given different supports to make it possible for them to have equal access to the game. They are being treated equitably.

In the third image, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The systemic barrier has been removed.

Source: https://twitter.com/constababble/status/730589497050587136


2 L.H. Nishii, Eliminating the Experiential Differences that Divide Diverse Groups through Climate of Inclusion


Branch Musings

New South Wales

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Vice Chairperson:  
Dr Robert Griffits
Hon Secretary:  
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Country Vice Chairperson:  
Dr Neale Mulligan

Towards the end of 2016, the NSW RANZCO Committee were working on refining the proposed Federal NSW by-laws for the Branches and Special Interest Groups. Throughout the year Barry Diletti, RANZCO Office Manager, has provided valuable assistance to the NSW Branch in organising catering and setting up complex teleconference facilities.

We congratulate two NSW Fellows who received honors on Australia Day. Dr Iain Dunlop, who was awarded a Member (AM) in the General Division for his significant service to ophthalmology, particularly through executive roles with the Australian Medical Association and other professional medical organisations, and as a medical practitioner. A/Prof Geoffrey Painter was awarded an AM for significant service to medicine in the field of ophthalmology, and to international relations, particularly to eye health in Asia and the Pacific.

Please join us for the combined NSW RANZCO/ISOO scientific conference on 24-25 March 2017 focusing on ocular oncology. Fantastic international speakers Drs Carol and Jerry Shields, Bertil Damato and Hans Grossniklaus together with Australian experts will educate us in this important and critical aspect of ophthalmology.

A/Prof Andrew Chang  
Chair, RANZCO NSW Branch

New Zealand

Chair:  
Dr Stephen Ng
Hon Secretary:  
Dr Andrea Vincent
Hon Treasurer:  
Dr Andrea Vincent

Ophthalmologists throughout New Zealand who work in the public hospital system have witnessed the unfolding, over the past two and a half years, of a crisis in delayed follow-up visits for our patients with chronic eye conditions. As described in an article in the Summer 2016 issue of RANZCO’s Eye2Eye, the crisis was precipitated by the New Zealand Ministry of Health (MoH) targets that required new referrals to have earlier and earlier appointments. The ‘unintended consequence’ of this action was that follow-up patients’ appointments had to be delayed. In some cases, this amounted to delays of four to six months or longer. Throughout New Zealand over 50,000 patients were affected. RANZCO New Zealand Branch estimated that (as a conservative estimate) approximately 1 in 100 patients were at significant risk of suffering visual loss. Every ophthalmologist will have personal experience of heart-breaking cases where patients suffered while waiting for their follow-up appointments. The crisis was compounded by the increasing scope of ophthalmology practice from the use of anti-VEGF agents and the increasing numbers of elderly people with chronic eye disease.

In November 2016, the RANZCO New Zealand Branch launched an advocacy campaign to television, radio and print media and all New Zealand parliamentarians, the MoH and the Minister of Health. Just before Christmas (21 December 2016), RANZCO NZ Branch welcomed the Minister of Health’s announcement that a $2m fund was being made available to deal with the crisis. This was a lower figure than we had lobbied for. Also, there is no funding currently available beyond the end of 2017. We estimated it would cost $5m to clear the backlog of follow-up appointments then $5-10m per annum in the future to prevent the crisis recurring. Furthermore, the MoH funding attached a number of restrictions on how the money could be spent, for e.g. purchasing of equipment and software were specifically prohibited. Nonetheless, throughout New Zealand, RANZCO Fellows are pleased that the follow-ups issue is now clearly ‘on the
agenda’ of the District Health Boards (DHBs) and the MoH. Previously, in 2015, the issue had been raised with the Minister of Health. This had not resulted in any significant government action to deal with the impending crisis.

RANZCO NZ Branch Fellows from ophthalmology departments around the country have now formed a RANZCO NZ Branch Advisory Group. This group will work in a ‘governance’ role to liaise with the MoH. In 2017, its role will be to collect data from the various hospital eye departments to monitor the DHBs’ management of the follow-up crisis. It aims to meet regularly with the MoH to ensure that locally-based and adequately funded solutions are made available to the DHBs. To ensure there is no repeat of the crisis in the medium and long term, RANZCO NZ Branch also aims to assist in investigating innovations in national models of care. RANZCO NZ Branch will be intimately involved with initiatives to deal with the looming future increases in demand for ophthalmology services. This includes assisting in the preparation of the long-awaited MoH analysis (Tier 3) for the future management of age-related macular degeneration. It is expected this work will act as a blueprint for the management of other chronic eye conditions, such as diabetic retinopathy and glaucoma.

In a sense, the hard work arising from the advocacy campaign is just beginning. The challenge now is for New Zealand ophthalmologists to use what has been gained from the advocacy campaign to again provide the level of care to our public hospital patients that has not been possible over the past couple of years, and for us to help shape future public ophthalmology services. It is a challenge that we gratefully accept.

Throughout the campaign, RANZCO NZ Branch has been grateful for the combined efforts of the RANZCO NZ Branch Executive, RANZCO Fellows involved with the RANZCO Leadership Development Program, and the Directors of Ophthalmology New Zealand and Macular Degeneration New Zealand. RANZCO NZ Branch is also grateful for the invaluable expertise of Helen Hunter, NZ Branch Support Officer, and Emma Carr and her Communications Team at RANZCO.

Dr Stephen Ng
Chair, RANZCO NZ Branch

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**Ophthalmology UPDATES!**

**29-30 July 2017**

**Westin Hotel, Sydney**

Register at www.ophthalmologyupdates.com

The revision and updates conference for all ophthalmologists

**Convener:** Adrian Fung

**Concora:** Stephanie Watson

**Uveitis:** Peter McCluskey

**Vitreo-retinal:** Andrew Chang

**Oncology:** Max Conway

**Oculoplastics:** Raf Ghabrial

**Electrophysiology:** John Grigg

**Cataract:** Geoff Painter

**Neuro-ophthalmology:** Clare Fraser

**Paediatrics:** Mike Jones

**Medical Retina:** Jenny Arnold

**Glaucoma:** Andrew White

**Medicolegal:** Paul Beaumont

**Younger Fellows Advisory Group**

Dr Nisha Sachdev, Chair of the Younger Fellows Advisory Group, has organised a lunchtime symposium on Saturday 25 March, sponsored by Avant.

**Speaker:** Michael Swan, Avant Law

**Topics:** Advertising and branding/marketing for young ophthalmologists and interesting medico legal cases.

To attend the symposium, you are required to register for the RANZCO NSW BRANCH Annual Scientific Meeting.
Special Interest Groups

Only a few days left until the ISOO 2017 and RANZCO NSW Branch ASM

The countdown has begun for the International Society of Ocular Oncology (ISOO) Biennial Conference on 24-28 March 2017. The conference will be held in conjunction with the 2017 Annual Scientific Meeting of the RANZCO NSW Branch, which will take place on 24-25 March.

The theme of the NSW Branch Annual Scientific Meeting is Ocular Oncology with an emphasis on Oculoplastic Surgery. There will be four exciting didactic sessions from charismatic global leaders, including Drs Jerry and Carol Shields, Bertil Damato and Santosh Honavar, who will share with us their insights and knowledge on many aspects of retinoblastoma, conjunctival tumours, lymphoma and eyelid and orbital tumours. This will be aimed at the general ophthalmologists but will also appeal to oculoplastic surgeons.

There will be a combined session with the ISOO titled ‘What the ocular oncologist can learn from the study of cutaneous melanoma’. We are very fortunate to have luminaries such as Professors Georgina Long, Richard Scolyer and John Thompson from the Melanoma Institute of Australia as well as world renowned speakers Drs Hans Grossniklaus, Bita Esmaei and Victoria Cohen to enlighten us.

The RANZCO NSW Branch Annual Scientific Meeting also has a strong multidisciplinary emphasis. We will hear about other disciplinary approaches to periorbital malignancy and then expand our knowledge of all aspects of the anophthalmic socket. The NSW Branch meeting will finish with an exciting film festival covering aspects of reconstructive surgery and some surprise elements. On Friday 24 March there will be an Ocular Pathology Workshop run by Dr Hans Grossniklaus from Emory University, Atlanta, Georgia. Fellows registered for the RANZCO component will have the option to attend any of the sessions on 24 and 25 March.

The social program is equally exciting and includes a Welcome Cocktail Reception at the newly built International Convention Centre at Darling Harbour. This is a state of the art venue right on Sydney Harbour and there are many excellent restaurants nearby.

Do not miss this extraordinary opportunity to hear and learn from world and local leaders and experience the magic as Sydney showcases its unique treasures.

The RANZCO NSW ASM program will feature:

- Four didactic 90 minute sessions by visiting international experts. These experts have each organised an international panel of speakers to assist them during the session.
- A 90 minute combined session on Saturday morning, 25 March, the theme of which will be how our knowledge of ocular melanoma can benefit from the study of cutaneous melanoma.
- An Ocular Pathology Course to be held on Friday 24 March run by Dr Hans Grossniklaus from Emory University, Atlanta, Georgia, USA. This workshop will run all day.

To view the full program, please visit the website at: http://iso2017.com/program-ranzco.php
The Art of Cornea in Brisbane

This year’s highly successful and well-attended Australia and New Zealand Cornea Society (ANZCS) conference was held in Brisbane on the day before the commencement of the ARVO-Asia conference. The venue was the beautiful Queensland Gallery of Modern Art (GOMA) at Southbank and the one-day conference attracted almost one hundred ophthalmologists, eye bankers and those interested in cornea and visual sciences.

The program was fast-paced but with ample time for discussion. It covered the whole gamut of corneal disease in one day — rather than over the normal annual two-day meeting — such that delegates could also attend ARVO-Asia the following day. Sessions were divided into sections that, amongst other topics, included advances, updates, new investigations, state-of-the-art, controversies and the annual Doug Coster Lecture.

Speakers included Drs Peter Beckingsale and Andrew Apel who were also the local coordinators of the conference. The principal guest speakers were Dr Mike Straiko (USA) and Professor Shigeru Kinoshita (Japan).

The global trend towards Descemet's Membrane Endothelial Keratoplasty (DMEK) was highlighted by a number of speakers but particularly in a beautifully presented ‘DMEK masterclass’ presented by Dr Straiko. However, it was quite clear that in the USA and Australasia the majority of endothelial keratoplasties are still successfully carried out using the DMEK forerunner, Descemet Stripping Automated Endothelial Keratoplasty (DSAEK). The majority of tissue for DSAEK is now being prepared by eye banks.

A simple, small, central Descemetorhexis without a transplant, i.e. allowing the defect to heal by sliding of peripheral endothelium, potentially enhanced by application of Rho-kinase (ROCK) inhibitors, was highlighted by Dr Greg Moloney (NSW). Dr Moloney also introduced the audience to the osteo-odonto keratoprosthesis (OOKP) program currently being established in Sydney, illustrating the first few treated cases.

Professor Stephanie Watson presented the compelling advantages of contributing to a corneal collagen crosslinking (CXL) registry for keratoconus, the increasingly well-established treatment for early, progressive keratoconus. Dr Con Petsoglou discussed the major development of the Sydney ocular BioBank.

In a landmark Doug Coster Lecture, Prof Kinoshita discussed the long journey from early laboratory studies, via animal models, to upcoming human trials of endothelial cell transplantation and the utility of ROCK inhibitors. In an academic tour-de-force Prof Kinoshita outlined the immediate clinical horizon for endothelial dysfunction using cultured endothelial cells and topical agents.

In a unique time of rapid changes in lamellar endothelial keratoplasty, it is now entirely conceivable that treatment by injection of cultured cells and application of topical agents will supplant more invasive surgical techniques within a decade.

Prof Kinoshita continued in a separate lecture to highlight the medical and surgical management of potentially devastating ocular surface disorders such as the Stevens-Johnson syndrome.

Dr Graeme Pollock provided an annual update of the Eye Bank Association of Australia and New Zealand’s (EBAANZ) activity and Dr Prema Finn highlighted key elements of DMEK tissue selection. One of the annual highlights of the conference, the Australian Corneal Graft Registry annual report, was delivered by Dr Miriam Keane.

The meeting ended with a clinical movie competition and a new section with interactive live polling of controversial topics. As always the mood was upbeat, informal, interactive and extremely cordial.

The location, the fabulous GOMA at Southbank, was convivial and refreshing. The conference dinner in the GOMA long gallery was a well-attended and most-enjoyably-friendly ending to a cutting-edge conference.

ANZCS, chaired by Professor Charles McGhee, met the evening before the conference to discuss development of the society, review of the constitution and the location of future conferences. It was provisionally agreed that the ANZCS conference would rotate to Sydney (2018), Adelaide (2019), Perth (2020) and Auckland/Queenstown (2021) to continue this highly collaborative cornea and eye bank meeting originally developed by Professor Douglas Coster in the 1980s.
The Australian and New Zealand Glaucoma Interest Group (ANZGIG) met for a highly successful and enjoyable Annual Scientific Meeting on 4 and 5 February in Brisbane this year. Dr Guy D’Mellow, ANZGIG Vice Chair, organised a program that was packed with both scientific and clinical content with contributions from both international and local speakers.

The Lowe Lecturer this year was Keith Martin, Professor of Ophthalmology, University of Cambridge. Prof Martin is a world leader in glaucoma, an inspiring clinician scientist who has a depth of knowledge in the neurosciences and in how that may translate to clinical care of our glaucoma patients. He has had a long relationship with antipodean glaucoma specialists, having trained many of our glaucoma colleagues. His lectures can be heard in full when the ANZGIG meeting is released on USB again this year, sponsored by Allergan. A real highlight was getting to know Prof Martin better in a new format session: ‘A Conversation with: Prof Keith Martin’ by Prof Ivan Goldberg AM. In an Oprah-like interview, we learnt how Prof Martin began in Northern Ireland and how he is where he is today. The Gillies Lecturer was Professor Stuart Graham from Sydney who spoke on his work ‘Vascular Factors Revisited’.

The topic of driving and glaucoma is both sensitive and important. We heard from leading speakers in a plenary session on ‘Driving and Glaucoma’ including visual field researchers, medical practitioners involved in producing regional guidelines, medical indemnity and Glaucoma Australia’s President Ron Spithill OAM. Following this stimulating session, a Driving Standards Subcommittee is planned, chaired by Dr Guy D’Mellow.

Our group was formed in 1988 as the Glaucoma Club, founded by Dr William (Bill) Gillies. The Club became ANZGIG in 2006. By a formal vote at our AGM, we have become a Society: The Australian and New Zealand Glaucoma Society (ANZGS).

The next ANZGS Annual Scientific Meeting will be in Sydney 23 and 24 February 2018. We hope you can join us.

A/Prof Anne Brooks
ANZGS Chair
Dr Ridia Lim
ANZGS Secretary/Treasurer
RANZCO Affiliates

The Ophthalmic Research Institute of Australia (ORIA) is supporting eleven medical eye research projects throughout Australia during 2017. The total to be funded is $539,205 during the year. Together with annual funding support for the Director of Research in Melbourne, the ORIA, and its supporters, will provide just under $750,000 during 2017.

The ORIA’s Research Advisory Committee, made up of 15 members, assessed 52 applications from Australian researchers and four from New Zealand. The assessment process is a significant task. We secured around 113 peer reviews for our 2017 assessments. The advice from our reviewers is invaluable. Dr Thomas Campbell who works out of the Gold Coast Hospital and the University of Queensland was deemed our ‘most useful’ reviewer. Tom nominates surfing as his favourite pastime. He has received an MBBS UQ, MSc Neuroscience Oxford and a DPhil Neuroscience, University of Oxford and his long term goal is to work across medical practice, academic research and teaching with a particular interest in Indigenous and outreach ophthalmology services.

We were delighted to fund the first two ORIA/Richard and Ina Humbley Foundation Grants. They have been awarded to Dr Fred Chen from the Lions Eye Institute, Perth for *Stem Cell Therapy for Age-Related Macular Degeneration* and Dr Jia Jia Lek from the Centre for Eye Research Australia in Melbourne for *Reticular pseudo-drusen (RPD): A high-risk factor for vision loss in age-related macular degeneration (AMD)*. Dr Lek is one of three New Investigators the ORIA is funding during 2017.

Since 1992, the ORIA has received an annual distribution from the estate of the late Mrs Margaret Anselmi, called the Hardie-Anselmi Trust. Mrs Anselmi kindly nominated the ORIA as one of four beneficiaries of the Trust. All distributions from that time have been used to fund medical eye research and no doubt supporting many Australian scientists. The terms of the will indicated that 25 years after Mrs Anselmi’s death, the Trust be wound up and the four beneficiaries receive a quarter of the capital. Late December 2016, the ORIA received $1.16million as its share. We are so grateful to our generous benefactors.

*Anne Dunn Snape,*
*Executive Officer, ORIA*

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**$1.16m**

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ASO Update: we’re after a real plan for health

“A week is a long time in politics.”

Former British Prime Minister Harold Wilson’s famous line never gets old. Here we are finally settling in to 2017 following the sudden departure of Health Minister Sussan Ley and then the surprise arrival of Greg Hunt in the role.

The new Minister’s resume lists several high profile jobs, including at least two ministerial portfolios, and our earnest hope is that he is ready to roll up his sleeves and get some things done.

The Australian Society of Ophthalmologists (ASO) will be working hard to establish an immediate rapport with him. Our aim will be to provide his office with valuable insight on issues impacting on our members and their patients.

The Australian health sector is under intense pressure and we need to see some tangible progress in a range of areas, most notably private health insurance regulation and affordability, as well as the Medicare rebate freeze.

To date the Turnbull Government has struggled to prove it has a clear direction for health policy. Right now the sector is desperate for a real plan for health from the Government and an efficient and capable Minister who can deliver it. Sadly, it may well be that Government has adopted and adapted the Hippocratic principle of “Do no Harm” to “Do Nothing”.

Business skills in 2017

ASO headquarters is a hive of activity as we prepare for this year’s ASO Business Skills Expo, to be held on Saturday 13 and Sunday 14 May at the InterContinental Hotel, Double Bay.

With each new year, the Expo builds on its scope as an educational event that is tailored to the needs of ophthalmologists and specifically those keen to develop their knowledge and skills in the business of ophthalmology.

In 2017, delegates will explore a diverse program of learning which has been developed following the detailed feedback gathered at last year’s event.

From industry updates, through to financial planning, super, and succession planning, each resource-filled session will be delivered by an expert who understands the specific needs of ophthalmologists.

In addition, this year we will have new and innovative ideas concentrating on ‘Building Your Business in a Competitive Market’.

Sessions investigating topics such as ‘Innovative approaches to marketing’ and ‘Web-based practice development strategies’ are currently being developed.

While we are medical specialists first, our role as business owners and/ or business professionals cannot be overlooked. We need to devote time and energy to developing strong skills in this arena.

This is the underlying hypothesis of the ASO Business Skills Expo.

We look forward to seeing you there!
Ophthalmology New Zealand (ONZ) wishes to congratulate the RANZCO NZ Branch for their strong stance and action on the dangerous issue of waiting lists in the District Health Boards (DHBs) of New Zealand. We also thank the NZ Branch for the opportunity to be involved and to lend our support to this campaign. The campaign itself has had a partially successful conclusion with the December announcement of funding. On 23 December Jill Lane, Director Service Commissioning, said “Recent discussions between the Ministry of Health and DHBs identified variability in terms of processes, systems and planning to support appropriate access to services. It also illustrated varying models of the care and workforce used to support eye health for New Zealanders.”

“In the short term, the Ministry’s support will include making available a contribution of up to $2 million nationally during 2016/17 to assist DHBs to develop, implement or improve care models to best support their district’s eye health.”

ONZ is pleased to see this initiative but also looks forward to engaging the Ministry of Health in more long term solutions.

ONZ also attended a meeting with Southern Cross Health Insurance in February. This meeting was to discuss the aggregated results of the Southern Cross Patient Survey. Our members will receive a complete update on this meeting by email.

Finally, we wish to advise of two events for our NZ colleagues:
1. The Clinical Directors Meeting. To be held on Tuesday 4 April in Wellington. With details to be advised, and
2. ONZ inaugural Business Forum. To be held on Sunday 14 May.

The ONZ Business Forum is a half day workshop to be held post the RANZCO NZ Branch meeting on Sunday 14 May. Topics involved will include:
• Financial management for stages of an ophthalmologist’s career
• Strategic planning for your practice
• Risk management in a public and private clinical setting
• HR legislation in your practice

Save the date for this forum, details will be forthcoming with members and non-members invited and with a discounted attendance fee for members.

2017 RANZCO WORKFORCE SURVEY

Did you know that, in the 2014 RANZCO Workforce Survey 21% of practicing Fellows and 53% of practicing trainees / registrars worked over 50 hours in a working week?

The RANZCO Workforce Survey plays a key role in helping the College plan its ongoing activities to support the Fellowship. Given the fast-changing medical and policy landscape, knowing where we stand helps us chart a course to where we wish to be.

2017 RANZCO WORKFORCE SURVEY COMING SOON 2017 mid-year
Congratulations to all Australia Day award recipients

Congratulations to the following RANZCO Fellows who made the 2017 Australia Day Honours List for their hard work and dedicated service to ophthalmology and vision care over the years:

**Dr Noel Alpins AM** - For significant service to ophthalmology, particularly to the development of innovative refractive surgery techniques, and to professional associations.

Dr Alpins has been practising cataract surgery and refractive surgery since founding NewVision Clinics in the 1990s. He is part of the Program Committee at RANZCO and since 2008 serves as Chair for the invited speakers subcommittee. In 2010, he was the invited Council Lecturer at the RANZCO Annual Scientific Congress in Adelaide, and at the 2017 meeting in Perth later this year he will be the Gregg Lecturer.

Dr Alpins is a clinical senior lecturer as an honorary senior fellow at the University of Melbourne. He is on the editorial board of many prestigious publications, including the American and European Journal of Cataract and Refractive Surgery, Journal of Refractive Surgery, Ocular Surgery News, Eurotimes and others. He has contributed over 150 articles in peer reviewed journals and ophthalmic information magazines as well as more than 20 book chapters. In 2015 he received the Certificate for Outstanding Contribution in Reviewing awarded by Elsevier.

He has invented new methods for treating and analysing astigmatism, published in the peer reviewed literature, and has developed the ASSORT surgical planning and outcomes analysis software program that is used by ophthalmologists globally. He speaks widely on these topics at national and international meetings. He has written a book on *Astigmatism surgery - planning and analysis*, which will be published this year.

He has received several awards during his career, including the International Society of Refractive Surgery (ISRS) and American Academy of Ophthalmology (AAO) Lans Distinguished Award in Chicago in 2012. He received the 2013 AAO Achievement Award and the ISRS Lifetime Achievement award in 2014 for his internationally recognised contributions to the advancement of refractive surgery over his career.

**Dr Garry Brian AM** - For significant service to ophthalmology, and to the provision of eye health care programs in rural and remote communities.

Dr Brian started regular clinic and surgery visits to the remote communities of the Torres Strait in 1987, and has continued to provide this service six weeks annually on Thursday Island. In the mid-1990s he was also the sole visiting ophthalmologist for remote Indigenous communities in northwest Queensland and on Cape York Peninsula, and at urban Aboriginal Medical Services in Far North Queensland. As a result of this work, the Australian federal government was persuaded to review the delivery of ophthalmic services to rural and remote Indigenous communities, with the intention of improving access and quality. Dr Brian was a consultant to the attempted implementation of the recommendations of that review.

Dr Brian spent six weeks in 1988 at the Eritrean People’s Liberation Front improvised wartime hospital at Orola. He operated on civilians and war trauma victims, and conducted the first skills transfer for Eritrean ophthalmic assistants. Since that time, much on a fulltime basis, he has been involved in eye care project planning, implementation, monitoring and evaluation in Africa, Asia and the Pacific. He has more than 90 peer-reviewed publications, most dealing with this work.
Over the last thirty years Dr Brian has held various positions with development NGOs, including Medical Director of The Fred Hollows Foundation in Australia (1998-2000) and New Zealand (2005-2010), and in the executive of the International Centre for Eyecare Education (2002-2004). He was instrumental in a rejuvenation of ophthalmic education in Papua New Guinea and the setting up of diploma and masters courses in Fiji, producing eye doctors for the Pacific region.

Dr Iain Dunlop AM - For significant service to ophthalmology, particularly through executive roles with professional medical organisations, and as a practitioner.

Dr Dunlop trained initially as a physician and later in ophthalmology at Sydney Eye Hospital with further study in London. At Sydney Eye Hospital, Dr Dunlop has been teaching Anterior Segment eye surgery since 1988.

Dr Dunlop has made outstanding contributions to RANZCO. He was Vice-Chairman and Chairman of the NSW Branch, a long term Honorary Secretary of the federal College, federal Council Member, Board Member, Honorary Treasurer, as well as College President from 2007 to 2009.

He has been strongly involved with the Australian Medical Association (AMA) over the years serving as federal Council Ophthalmology representative as well as AMA ACT President immediately following his College presidency. Later, Dr Dunlop became Chair of the AMA federal Council and, more recently, has been on the Board of federal AMA and is now its Chair.

Late last year, Dr Dunlop stepped down from Vision 2020 Australia after 12 years as an ophthalmology presence on its Board.

"I have been amply rewarded by the warmth and stimulation of a career both as a clinical doctor and as one who has had the chance to contribute to development of good policy and to turn aside bad policy. The Australia Day award is a great honour which I feel belongs just as much to all those with whom I have worked. We have a wonderful profession which is worth our involvement and our protection," said Dr Dunlop.

A/Prof Geoffrey Painter AM - For significant service to medicine in the field of ophthalmology, and to international relations, particularly to eye health in Asia and the Pacific.

After initial medical training at the University of Sydney and Royal North Shore Hospital, A/Prof Painter undertook ophthalmology training at Sydney Eye Hospital. This was followed by a cataract and glaucoma fellowship at Addenbrooke’s Hospital in Cambridge, UK.

Returning to Australia he co-founded Gordon Eye Surgery, a multi-surgeon, comprehensive ophthalmic practice where he continues in private practice today specialising in cataract surgery and glaucoma.

Dr Keith Zabell OAM - For service to medicine, particularly to ophthalmology.

Dr Zabell is an Honours Graduate from University of Queensland Medical School and trained as an Ophthalmic Surgeon at the Sydney Eye Hospital and also at the Bristol Eye Hospital in England. He is a Senior Lecturer at the University of Queensland, Rural School of Medicine.

Community Eye Care: A/Prof Andrew White leads pilot of collaborative care model

In 2013, Associate Professor Andrew White and Dr Ivan Goldberg AM published a paper in RANZCO’s scientific journal CEO on Guidelines for the collaborative care of glaucoma patients and suspects by ophthalmologists and optometrists in Australia. The paper advocated for a collaborative care approach to glaucoma care, with ophthalmologists and optometrists working together to deliver effective and efficient patient care, drawing on the success of similar models in the UK and other countries.

Importantly, in their paper White and Goldberg noted the “fundamental and unbridgeable gap between an ophthalmologist’s skills and knowledge compared with that of an optometrist” saying that to “diminish or deny this difference would run counter to the achievement of the highest standard of care and safest practice”.

This approach aligns well with RANZCO’s launch last year of referral guidelines for glaucoma management, which provide a clear guide for optometrists to use in making referral decisions about glaucoma patients or patients presenting with potential glaucoma symptoms. The guidelines help to ensure that where the skills and knowledge of an optometrist are appropriate, a patient will be managed by them, but where the skills and knowledge of an ophthalmologist are required, a patient will be referred on. This not only ensures that the patient gets the most appropriate care and support, but it also ensures that optometrists and ophthalmologists are concentrating their efforts on the patients in need of their specific skills.

Following on from this paper, in January this year Westmead hospital eye clinic launched a pilot of Community Eye Care (CEYE) a new
Join the Kera Club!

In late 2016, Kera Club, a joint initiative of Save Sight Institute and Keratoconus Australia, was launched at the Sydney Eye Hospital. The club provides a forum for people affected by keratoconus – patients, their friends and families – and the ophthalmologists, optometrists, researchers and other professionals who study and treat keratoconus.

As President of Keratoconus Australia Larry Kornhauser explained at the event, the purpose of the club is to bring people together to share their stories, to provide information about the condition and its treatments and to support each other. Keratoconus is a rare disease, meaning that people who are diagnosed with it may never have heard of it before. It is also progressive, so patients know that their vision could get much worse over time. Understandably, many people with keratoconus need support to understand their condition, allay their worries and get to grips with treatment options. Keratoconus Club provides that.

For violinist Michelle Urquhart, the keynote speaker at the inaugural Kera Club and a long time keratoconus patient, Kera Club represents an opportunity for people like her to gain insight into their condition and feel more in control. “The more we understand the condition, the better we can understand the options open to us, and the better we can look after ourselves. I was diagnosed as a teenager and I felt very unsure about what the future held for me. Since then, I’ve had three corneal grafts and a number of serious infections. I’ve spent huge amounts of time in hospital. With fluctuations in my eyesight, there were times when the whole world was fuzzy to me, times when I couldn’t even make out the features of my beautiful babies’ faces.”

“I’ve learnt a lot about my condition since then, and the treatments available have progressed. For example, the advancements being made in terms of collagen cross-linking are very exciting. Kera Club allows people like me to interact directly, in an informal way, with ophthalmologists and optometrists who can answer our questions and provide information about the latest developments, such as cross-linking. And hearing from other people who are affected by keratoconus lets us know that we are not alone, and gives us hope for our futures.”

As well as bringing together patients and clinicians in a forum of support and information sharing, Kera Club provides an enlightening view of the benefits of collaborative working, in particular between ophthalmologists and optometrists. Speakers at the inaugural event included Clinical Professor Stephanie Watson, Chair of the RANZCO Public Health Committee and Ocular Repair Group Leader, Save Sight Institute at the University of Sydney, and optometrist Dr Margaret Lam. Prof Watson explained the advances that are being made in treatments for keratoconus, particularly with collagen cross-linking. She also explained how the disease can progress and what the risks are. Dr Lam explained how contact lenses can be used to both improve sight and protect the eye from dust and allergens. Prof Watson and Dr Lam then both gave an interesting insight into how they work together to ensure the best possible outcomes for their keratoconus patients, many of whom need a great deal of ongoing support.

“It’s important that ophthalmologists and optometrists work together so that keratoconus can be identified and intervention can begin early. Once a diagnosis is made, patients with keratoconus must be carefully monitored so that any changes in their condition can be managed and vision loss mitigated as much as possible. I work closely with optometrists, including Dr Lam, so that we can share knowledge and experience with each other and so that we can ensure that our patients are getting access to the best possible care,” explained Prof Watson. “For patients with keratoconus, onset in childhood or as a young adult brings with it the burden of life-long visual disability. Quality of life in keratoconus can be...
lower than that for age-related macular degeneration, with mental health, role difficulty, driving, dependency and ocular comfort affected. I see Kera Club playing an important role in supporting patients to achieve best vision and outcomes. I am grateful to Michelle Urquhart for leading the meeting and sharing her experiences.”

Dr Lam explains that collaborative working has benefited her patients enormously, while also helping her to expand her knowledge and share her insights with ophthalmologists. “My experience co-managing patients’ care with ophthalmologists has been very positive. The work that I do, in terms of specialised contact lenses, complements, and is complemented by, the care my patients receive from ophthalmologists. When eye care practitioners work together there is a lot of synergy in what we do and patients really benefit. As care providers, we all need to work within our scope of expertise, while being open minded about working with others whose skills can further benefit patients. It improves outcomes for our patients and makes us all better eye care practitioners.”

If you are interested in attending Keratoconus Club in NSW or would like to recommend it to your patients, please email Michelle Urquhart, in her role as NSW Keratoconus Club point of contact, at nsw@keratoconus.asn.au or the Save Sight Institute at ssi.community@sydney.edu.au for more information.

If you are interested in attending Keratoconus Club in NSW or would like to recommend it to your patients, please email Michelle Urquhart, in her role as NSW Keratoconus Club point of contact, at nsw@keratoconus.asn.au or the Save Sight Institute at ssi.community@sydney.edu.au for more information.

Older Australians with Vision Loss and Blindness - Help is Needed Now


The report highlights the evidence base supporting the benefits of aids and technologies for those with vision loss and blindness in order to connect and engage with the world, maintain independence and enhance quality of life.

However, despite these benefits, there are barriers to accessing low vision aids in Australia, particularly for those most in need - the 100,000 older Australians with vision loss and blindness. The major barrier is cost.

For over a decade, responsibility for a funded equipment program to ensure affordability of aids and technologies has been shuffled between state and federal governments, between numerous portfolios in health, ageing and disabilities, and finally falling between the gaps of aged care and disability reforms.

Barriers to access also include highly fragmented services, inadequate referral pathways and inadequate co-management plans between eye care practitioners and low vision services, along with poor consumer information and knowledge regarding services.

Julie Heraghty, CEO of MDFA, said, “Low vision aids, ranging from a simple magnifier or specialised lighting through to adaptive technology, can transform the lives of people with sight loss, helping them to live fulfilling, independent lives. Currently, the vast majority of people in Australia with sight loss have great difficulty affording or accessing these aids. This needs to change.”

Heraghty stated “While successive governments are to be commended for subsidising registered sight saving drugs to avoid vision loss, unfortunately many older Australians who are vision impaired or blind are repeatedly missing out on the support they most need – low vision aids and technologies.

“This new, Australian-first report documents the value and effectiveness of low vision aids and technologies, the barriers to access, and the reasons why this issue must be placed on the government agenda. Recommendations proposed in this report are financially achievable and the Foundation will be urging the new Minister for Health to provide older Australians, who are locked out of the National Disability Insurance Scheme, the funding and a mechanism to be able to access the support they so desperately need and deserve,” said Heraghty.

Initial cost estimates of a federally funded program presented by MDFA indicate that the cost of implementation and evaluation could be as little at $30 million per year with a suggested annual allowance of between $667 and $2,400 per person per annum depending on vision assessment.

New Avant-RANZCO partnership to shape the future of ophthalmology

RANZCO and Avant have joined forces in a new three-year partnership to support the development and leadership of the ophthalmology profession.

The partnership will support the advancement of research, education, leadership and advocacy skills for ophthalmologists and trainees. It cements a long standing relationship, with Avant supporting RANZCO’s Annual Scientific Congress and Special Interest Group meetings for many years.

Adam Golabek, Head of Partnerships at Avant, said “As an organisation focused on quality, safety and the professionalism of doctors, we see an important synergy between our objectives and RANZCO’s commitment to education, training, research, advocacy and standards.”

The partnership will support RANZCO’s Continuing Professional Development (CPD) Program through ongoing development of knowledge and skills in relation to clinical expertise and risk management, clinical governance and professional values.

The Avant partnership will also support the RANZCO Leadership Development Program which is part of RANZCO’s charter to build leadership and advocacy skills among Fellows by developing strategic thinking, leadership, communication and collaboration skills.

Dr David Andrews, CEO, RANZCO said, “RANZCO has partnered with Avant to work together to increase the quality, safety and professionalism of our respective members with a focus on driving research and professional education, and improving risk management, leadership skills and advocacy.”

The Avant Mutual Group stand at the 2016 RANZCO Annual Scientific Congress, Melbourne
Last year, Vision 2020 Australia appointed two new Board members: ophthalmologist Dr Anthony Bennett Hall and optometrist Dr Andrew Harris. Three Board members, Karen Hayes, John Howie and Maureen O’Keefe, were reappointed to serve another term. We speak to new Directors Andrew and Anthony about their roles at Vision 2020 Australia and insights into their respective fields.

Anthony Bennett Hall
Anthony Bennett Hall initially studied in Zimbabwe to be a GP. During his time as a provincial medical officer he realised he didn’t feel equipped to manage and treat the eye problems he encountered in rural areas. As part of his degree, Anthony elected to learn about basic eye diseases and was taught how to do intracapsular cataract extractions. In rural Zimbabwe, Anthony’s knowledge of eyes was considered unique and he was approached to run a small eye clinic at a mission hospital in Lesotho.
Buoyed by the results, Anthony had a career change and decided to pursue ophthalmology. He is currently a Vitreo-Retinal Surgeon in Newcastle and a Conjoint Senior Lecturer in Ophthalmology at the University of Newcastle. He has been involved in eye care for over 30 years and been a consultant ophthalmologist for 20 years.

Q What new technology or treatments should ophthalmologists look out for in 2017?
A My personal view is that we are perhaps a bit too quick to try and embrace what often seems to be industry driven new technologies before they have been subject to appropriate trials and peer review. If anything new comes along let’s make certain that it has been properly assessed.

Q What do you think will be the biggest changes in ophthalmology over the next few years?
A I believe the biggest challenge in Australia will be our ageing population. We will have to provide care to many more people with age-related eye problems. Globally, the population is ageing but the number of people living with diabetes is increasing even more. Sight threatening diabetic retinopathy is going to provide the greatest challenge.

Q Have you noticed any changes in the types of conditions patients are presenting with since you first started practising as an ophthalmologist?
A There are many more people living with diabetes and presenting with sight threatening diabetic retinopathy. I no longer see people blinded by measles and Vitamin A deficiency, which is a great victory for blindness prevention through vaccination and Vitamin A distribution.

Q What inspired you to join the Vision 2020 Australia Board?
A Vision 2020 Australia is the peak body representing all the blindness prevention key players in Australia and our region. It plays a vital role in providing advocacy for blindness prevention. I have witnessed the Vision 2020 movement make a huge difference in eye care in Africa and am excited to be part of that in this region.
**Q** What are you most looking forward to in your new role?

**A** Learning from other people. I am looking forward to working alongside eye care professionals from different organisations who share a passion for preventing blindness. There is so much we can learn from one another.

**Andrew Harris**

Andrew Harris has been an optometrist for over 25 years. For 15 years, he served on the National and Victorian Division Boards of Optometry Australia. During his tenure as President of Optometry Australia, he helped to negotiate the end to the fee cap for optometry services giving optometrists more opportunity to invest in services and equipment. The end result is a more flexible primary eye care sector, better diagnostic outcomes for patients and a reduction in the risk of under or over referring.

**Q** What new technology or treatments should optometrists look out for in 2017?

**A** The use of OCT imaging will continue to become a more mainstream investigation. This also is true for corneal assessment with topography and more patient friendly visual field assessments. Ophthalmology and optometry are working in a more integrated way than ever before. Contact lenses and spectacle lenses continue to improve and a broader range of products demands optometrists stay on top of what is available and appropriate for their patients.

**Q** What do you think will be the biggest changes in optometry over the next few years?

**A** With an ageing population there will be greater demand on the entire eye care workforce. There will be a requirement for greater efficiency, integration and cooperation. Treatment for diabetic retinopathy/macular oedema, macular degeneration, glaucoma and the like will change as will referral criteria and roles within the health system. Along with technology and technique changes there will have to be a flexibility to embrace change for beneficial outcomes in our community.

**Q** Have you noticed any changes in the types of conditions patients are presenting with since you first started practicing as an optometrist?

**A** There are definitely more people with diabetes and the related eye diseases that accompany that. When I graduated, intraocular lenses were coming into their own as aphakic lenses were being phased out. Cataract surgery is absolutely fantastic now. Macular degeneration is easier to diagnose as there are successful interventions and glaucoma is being managed more successfully. Consequently there is a relative drop in low vision patients although an ageing population means there are many people with low vision.

**Q** What inspired you to join the 2020 Australia Board?

**A** The eradication of avoidable vision impairment and blindness is a simple and appropriate ideal. The landscape is changing in this area (technology, population demographics, workforce etc.) and being part of the discussion and response has appeal to me. My previous experience gives me some skills to hopefully make a positive contribution in this area.

**Q** What are you most looking forward to in your new role?

**A** To work with a team (Vision 2020 Australia Board, staff and the sector as a whole) to effect some positive change and use some different skills from my clinical skill set.

As the national peak body for eye health and vision care, Vision 2020 Australia advocates to Government in partnership with members for policy change and for the funding of programs that will eliminate avoidable blindness and vision impairment. Advocacy activities also focus on ensuring the full participation in society of people who are blind or vision impaired in Australia and our region. Vision 2020 Australia’s strong membership base includes organisations and businesses representing optometrists, ophthalmologists, service providers, educators and researchers.
My first conversation when I arrived in Manchester was with a cab driver from the airport. He explained to me that Manchester weather was so terrible that even London weather was great in comparison. My heart sank. Unfortunately, the taxi driver was correct on his prediction, but despite the rain I thoroughly enjoyed both the job and the broader experience and I would recommend Manchester as a fantastic place for a fellowship.

Clinical work
I undertook the corneal, ocular surface and refractive surgery RANZCO/Allergan fellowship at Manchester Royal Eye Hospital. It is the second largest eye hospital in the UK and sits within a large campus that also includes The Manchester Royal Infirmary, The Royal Children’s Hospital and St Mary’s Hospital (a women’s hospital).

This fellowship provided an excellent tertiary level corneal and anterior segment training program. The surgical volume was high and included training in all the modern corneal transplant techniques (including PK/DSEK/DALK/DMEK). There was also plenty of complex cataract surgery and anterior segment reconstruction.

This is one of the few fellowships that provides thorough training in refractive surgery, with one day per week spent in a private refractive facility. The fellow performs preoperative assessment and counselling of patients, the refractive surgery itself and the postoperative management of patients. Interestingly, the facility treats National Health Service (NHS) patients, giving them access to the excimer laser for conditions such as post-graft astigmatism and band keratopathy.

The corneal clinics I experienced were busy and amazing. There were at least 60 patients in each clinic, many of whom had complex corneal and ocular surface conditions. As a tertiary referral centre, this exposure to such a high volume of diverse cases was one of the highlights of the fellowship.

Research
Manchester Royal Eye Hospital is a major research centre in the UK. My main research focus at the unit was the analysis of prognostic factors in paediatric keratoconus. Children with keratoconus who had not had corneal cross-linking were analysed, to search for possible predictors of progression. As expected, children who, at presentation, had thinner central corneal thickness, higher mean keratometry and higher central posterior elevation were most likely to progress. These children seem to progress at a variable rate including some cases that progressed very fast. Interestingly, a number of children did not progress, or progressed very slowly. Some authors now advocate cross-linking all children with keratoconus at presentation, on
the assumption that most cases will progress. Our results suggest that perhaps some of these children who are at low risk of progression could be closely observed. This research was presented at the European Society of Cataract and Refractive Surgeons meeting and has been accepted for publication.

One of the highlights of my fellowship was attending the DMEK Wetlab Instructional Course in Rotterdam taught by Dr Gerrit Melles, a world renowned corneal surgeon. This opportunity to try to refine our DMEK technique was invaluable and has already improved outcomes from the procedure in Manchester.

Away from work
Manchester is passionate about football and it became clear that I was expected to support either Manchester United or Manchester City. A significant percentage of most Mancunians' time seems to be spent talking about football players, coach transfers, WAGS (the players' wives and girlfriends) and the rivalry between the two local teams, so it is important to be able to contribute to this (nuanced) conversation. I was lucky to get to a number of games including the FA Cup final. I'd recommend a game at Old Trafford to anyone!

There is, of course, more to Manchester and the north of England than football. There are the nearby Lake and Peak districts, beautiful old towns such as York and Durham, the country lanes of Cheshire and the Welsh-speaking north of Wales. To the south, London is only two hours by train while mainland Europe is easily accessible from both Manchester and Liverpool airports.

The NHS
I was warned before venturing to the UK that the NHS is a massive bureaucracy with plenty of inefficient features. I was encouraged to try to appreciate its good bits, of which there are many. The volume of patients that get seen is incredible. The clinicians are vastly experienced and their commitment to the NHS is impressive. There are also plenty of frustrations in the NHS. The system can be disorganised, such as when patients find out about their appointments after their appointment date has already passed. The junior doctor strike (which included a complete walk out of all junior doctors in all hospitals across the UK) highlighted dissatisfaction amongst junior doctors, as changes to their contracts were debated in Parliament. The recent Brexit debate was also of interest, as the ‘leave’ campaign believe leaving the EU will mean more NHS funding, while the ‘remain’ side highlighted that 10% of the UK’s doctors who work in the NHS are actually European. It has certainly been an interesting time to be in the UK!

The UK remains a great place for a fellowship and although it continues to become more challenging to get visas, working permits and General Medical Council accreditation, it is definitely worth the effort.

Dr Alex Hamilton

RANZCO Office
New RANZCO staff member

Monica Nation
Coordinator, Education

I had initially started at RANZCO as a temporary employee, and have recently been given the fantastic opportunity to become a permanent member of the RANZCO team as Coordinator, Education.

In my role I work closely with the manager of Continuing Professional Development (CPD) and the CPD and Professional Standards Committee, and assist in the coordination of the RANZCO CPD Program. My responsibilities also include assistance with recertification/revalidation, clinical audits and the practice accreditation program. In times of high work volume, I also serve as a resource to the Vocational Training Program team.

I came to RANZCO from a medical administrative background, starting my career as a medical receptionist in a high volume multi GP practice, then moving into administration for a mental health facility that catered to adults with mental health concerns, as well as their family and carers. I also have a Bachelor’s Degree in Medical Science, majoring in Biomedical.

In my spare time I enjoy spending time with my family and friends. I look forward to doing some international travelling, however in the near future my partner Rohan and I endeavour to first travel around Australia and visit all the beautiful landmarks and cities of our beautiful country.

Dr Alex Hamilton
Dr Bruce Bamford Martin
9 March 1926 – 30 November 2016

Dr Bruce Martin was born in 1926. His secondary education was completed at Prince Alfred’s College and his initial tertiary education resulted in a Diploma of Optometry in 1945. Bruce completed a Bachelor of Science degree in 1957, and then entered the Adelaide School of Medicine, graduating as a Bachelor of Medicine and Surgery in 1963.

Bruce was employed as a medical intern at Kent County Hospitals in 1963, and commenced his ophthalmology studies at the Kent County Hospital, Maidstone. He graduated with the Diploma in Ophthalmology of The Royal Colleges of Physicians and Surgeons of London in 1965.

Returning to Adelaide, again funded by working as a ship’s surgeon, Bruce commenced private practice in ophthalmology in Adelaide in 1965. In addition, Bruce worked as Honorary Consultant Ophthalmologist at the Royal Adelaide Hospital until 1967, and the Adelaide Children’s Hospital until 1991. He retired from full time ophthalmology in 1999, but continued to teach and advise in paediatric strabismus, and work as an Ophthalmic Surgical Assistant until 2006.

Bruce served as a Consultant Ophthalmologist for the Low Vision Centre of The Royal Society for The Blind, starting in 1998 until 2010.

During his career, Bruce published two significant original papers in the medical and scientific literature. The first, on the existence of binocular functions in childhood squint, and the second on the successful surgical management of neonatal glaucoma.

Bruce was a composer, pianist and a church organist from 1945-1962. He was a keen gardener, golfer, fisherman, and wood turner. He was an active member of the Brownhill Creek Rotary Club, becoming President, and later an Honorary Life Member.

During the period from 1977 to 1982 Bruce worked tirelessly with a medical colleague to raise funds for the East Torrens District Cricket Club to make the club independent of tobacco company sponsorship, thereby raising public awareness of health issues in the sporting world. Their efforts ultimately achieved the banning of tobacco company advertising at sporting events in Australia.

I worked with Bruce from 1971 until his retirement from private practice. His employees over a 30-year period adored him.

Bruce’s humanity and his outstanding ability to relate to, and to work with, children at a level which the child could understand was unique. Frequently he would not send an account or would accept an insurance rebate only, as he always considered the care of the child’s eyes to be paramount, and the parent’s economic circumstances unrelated to the treatment required for the child.

Throughout his working life, he was a shrewd and accurate observer and a modest but great teacher.

Dr Walford Thyer
Dr David Louis Rich
24 July 1922 – 22 March 2016

Dr David Rich was born in 1922 in Sydney. He was an ophthalmic surgeon, architect, builder, painter, musician, photographer, tour guide, horticulturist, Rotarian, chef, woodturner and bonsai master.

David was educated at Scots College and then Cranbrook. He excelled in sport at both schools. In 1933, he coxed the Second IV to victory at the Annual Head of the River Regatta. This was the first time Scots had won any race in the event. An Arthur Mailey cartoon in the Sydney Morning Herald showed a very small boy with a huge megaphone and enormous black glasses! After matriculating from Cranbrook, he went to Sydney University where he gained his medical degree in 1945, doing the six-year course in five years. It was at University he met Joan Macartney, also studying medicine. They were married in Sydney at the Great Synagogue in June 1946.

After a year working at Royal Prince Alfred, in 1948 the family moved to Tamworth where David undertook his residency at Tamworth Base Hospital. In 1950 he returned to Sydney and set up his practice in North Sydney.

In 1951 David entered a competition in the Women’s Weekly. His house design won the competition. The headline in the Women’s Weekly stated: “Doctor wins £2000 for brilliant plan”. Because both his brother and sister-in-law were architects, the judges at first did not believe he had drawn the plans himself. So they called him in one Saturday morning and asked him to redraw the plans from memory. And this he was able to do. A few days later, he was in the operating theatre at Royal North Shore Hospital and received a phone call. “Frank Packer wants to see you immediately.” So in he went to the Women’s Weekly offices in Elizabeth Street, and in to Frank Packer’s office. Frank Packer handed him the 2000 pound cheque with the words “here’s your money and don’t do it again”! The Women’s Weekly article stated that he would have made a superb architect if he hadn’t chosen medicine as a career.

He wrote a letter to Consolidated Press after his win. In part he said “Would you please convey my thanks also to the judges for their courtesy in what turned out to be, I’m told, such a difficult task. And especially do I ask you to convey my appreciation for the very genteel manner in which they expressed their suspicions and the delicate way they put me through the third degree.”

With the money he won, he bought some land in Wahroonga. He then designed and built the house that was to be their home for 65 years.

When he started his practice, the shingle was going to say “Diseases of the Eye”, but he felt that, by mentioning diseases, he would not have any patients. So the shingle simply said “Dr David L Rich, Affections of the Eye”.

From then on, his practice grew and he became a well-known and very well-respected ophthalmologist. He undertook honorary work at The Royal North Shore Hospital. He was also one of a group of doctors approached for input into building the North Shore Medical Centre, probably the first of its kind, where doctors of all specialties were able to set up their practices so close to a hospital.

Besides his own practice and the honorary work at North Shore, he also worked at The San, consulting, operating and teaching the nurses. He said of his work, “Doctoring has given me my greatest fulfillment. To take a child with squinting eyes and to make her into a beautiful lady is a great feeling. I love the delicate use of the hand for eye surgery.”

During this time, he became the President of the North Sydney Rotary Club.

David became very involved in bonsai. He held bonsai classes and organised the first national Bonsai convention. He also started the magazine Bonsai Down Under.

When he finally retired, David just couldn’t sit still! For ten years, he took groups to China – he would come back with hundreds of photographs, many of which were used on the front of travel brochures. He was interested in videos and the China videos overtook the still photographs. He also set up a video editing studio.

David believed age should be no barrier to keeping a healthy interest in life, achieving as much as possible and sharing the knowledge.

In an interview, he said “It’s nice to do something different. You only pass through this way once. And one likes to make as many stops on the way as one can. I feel sorry for people who retire and do nothing, who think all they want to do is retire on a beach. It’s 90% of people that don’t appeal to me at all.”

David is survived by his daughter Rosemary, sons Andrew and Anthony, grandchildren Tanya, Ben, Lucy and Emily. His wife, Joan and son, Adrian, passed away before him.

Rosemary Lithgow
# Calendar of Events 2017

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<th>EVENT</th>
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| **Cornea & Contact Lens Society Annual Conference** | 23-25 March 2017  
Rutherford Hotel Nelson  
27 Nile St W  
| **International Society of Ocular Oncology (ISOO) Biennial Conference together with the RANZCO-NSW ASM** | 24–28 March 2017  
Convention Centre  
Darling Harbour  
| **8th World Congress on Controversies in Ophthalmology (COPHy)** | 30 March to 1 April 2017  
Madrid Marriott Auditorium  
Av. de Aragón, 400  
| **SA RANZCO Biennial Scientific Meeting** | 8-9 April 2017  
The Sanctuary, Adelaide Zoo  
1 Plane Tree Drive  
Adelaide, SA, Australia | W: [www.ranzco.edu and go to the calendar of events](http://www.ranzco.edu) |
| **ARVO Annual Meeting** | 7-11 May 2017  
The Baltimore Convention Center  
1 W Pratt St  
Baltimore, United States Of America | W: [http://www.arvo.org/am/](http://www.arvo.org/am/) |
| **RANZCO New Zealand Branch Annual Scientific Meeting 2017** | 12-13 May 2017  
Copthorne Hotel  
Bay of Islands  
Paihia, New Zealand | W: [www.ranzco2017.co.nz](http://www.ranzco2017.co.nz) |
| **The Royal College of Ophthalmologists Congress 2017** | 22-25 May 2017  
Arena & Convention Centre,  
Kings Dock St,  
Liverpool L3 4FP, United Kingdom | W: [www.rcophth.ac.uk/events-and-courses/annual-congress-2017](http://www.rcophth.ac.uk/events-and-courses/annual-congress-2017) |
| **ANZSRS Mid-Year Meeting** | 3-4 June 2017  
Hilton Sydney  
488 George Street  
Sydney, NSW, Australia | C: meredeith@mdevents.com.au |
| **Tasmanian Branch Annual Scientific Meeting** | 10-12 June 2017  
Hobart Function and Conference Centre  
1 Elizabeth Street  
Hobart, Australia | C: andrew@conferencedesign.com.au |
| **European Society of Ophthalmology (SOE) Congress 2017** | 10-13 June 2017  
Barcelona International Convention Centre  
Plaça de Willy Brandt, 11-14  
| **1st Swiss International Ophthalmology Conference, Geneva** | 16-17 June 2017 | W: [www.ranzco.edu and go to the calendar of events](http://www.ranzco.edu) |
| **7th World Glaucoma Congress** | 28 June - 1 July 2017  
Messukeskus Helsinki, Expo and Convention Centre  
Messuaukio 1, 00521  
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| MACULART 2017                                      | 2-4 July 2017  
Palais des Congrès  
2 Place de la Porte Maillot  
com/2017/#.WFBaiWe7qpo                                                                 |
| Oxford Ophthalmological Congress - 2017            | 3-5 July 2017  
New Theatre Oxford  
George St  
Oxford OX1 2AG, United Kingdom | W: http://www.oxford-  
ophthalmological-congress.org.uk/                                                                 |
| ODMA 2017                                          | 7-9 July 2017  
International Convention Centre  
Sydney (ICC Sydney)  
Kent Street  
| Paediatric Special Interest Group Scientific Meeting | 13-15 July 2017  
Sofitel Noosa Pacific Resort  
14-16 Hastings Street  
Noosa Heads, QLD, Australia | C: Dr James Elder  
E: james.elder@rch.org.au                                                                 |
| Ophthalmology Updates! Conference 2017             | 29-30 July 2017  
Westin Hotel  
Heritage Ballroom, 1 Martin Place  
Sydney, NSW, Australia | W: www.ophthalmologyupdates.com                                                                 |
| AUSCRS Meeting 2017                                | 2-6 August 2017  
Hamilton Island Conference Centre  
| Queensland Branch Annual Scientific Meeting        | 4-5 August 2017  
Sheraton Grand Mirage Resort,  
Gold Coast  
71 Seaworld Dr  
Main Beach, QLD, Australia | C: Ty Fleming  
P: +61 7 3851 4298  
E: admin@simbiz.com.au                                                                 |
| Health Business Excellence Program - Sydney        | 26-27 August 2017  
Hilton Sydney  
488 George Street  
Sydney, NSW, Australia | C: Jess  
P: 0410 002 345  
E: admin@simbiz.com.au                                                                 |
| Australasian Academy Of Facial Plastic Surgery (AAFPS) & Blepharoplasty Australia Masters' Symposium on Blepharoplasty and Facial Rejuvenation | 1-2 September 2017  
International Convention Centre  
Sydney (ICC Sydney)  
Kent Street  
Sydney, NSW, Australia | E: info@aaafps.com.au                                                                 |
| American Society Of Cataract And Refractive Surgery (ASCRS) 2017 | 5-9 September 2017  
Los Angeles Convention Centre  
1201 S Figueroa St,  
Los Angeles, United States Of America | W: www.ranzco.edu and go to the  
calendar of events                                                                 |
| European Society Of Retina Specialists (EURETINA) 2017 | 7-10 September 2017  
Barcelona International  
Convention Centre  
Plaça de Willy Brandt, 11-14  
Barcelona, Spain | W: www.ranzco.edu and go to the  
calendar of events                                                                 |
| International Cornea And Contact Lens Congress     | 8-10 September 2017  
Sofitel Sydney Wentworth  
61-101 Phillip Street  
Sydney, NSW, Australia | W: http://www.cclsa.org.au/events/  
event/icclc-2017/                                                                 |
| NOSA 2017                                          | 14-17 September 2017  
Sheraton on the Park  
161 Elizabeth Street  
Sydney, Australia | W: www.ranzco.edu and go to the  
calendar of events                                                                 |
## Positions vacant

**OPHTHALMOLOGIST POSITION**  
**BACCHUS MARSH, VICTORIA**

Our thriving Ophthalmic Practice in Bacchus Marsh, Victoria has positions available for ophthalmologists. We service a large area treating a variety of eye conditions, including cataract, retina and glaucoma. We would like a general ophthalmologist preferably with subspecialty interest in ocular plastics/ paediatric ophthalmology/ glaucoma.

The practice is able to offer a variety of sessions. We have a complete range of the latest equipment in our clinic, including a Heidelberg Spectralis, angiogram/OCT, Tango SLT/YAG laser, Ellex Green/red pattern laser photo coagulator, Ellex iCubed B Scan, Galilei corneal topography, IOL master Humphreys Visual Field and networked electronic medical system.

C: Doriana Fletcher  
P: 0488 181 173  
E: dfletcher@bacchusmarsheyeclinic.com.au

**FULL TIME/ PART TIME OPHTHALMOLOGIST**  
**WAGGA WAGGA, NSW**

We require a general ophthalmologist to join our team in one of Australia’s largest inland cities.

You will have an interesting mix of patients coming from hundreds of kilometres away.

Support from fully trained staff and access to all of the latest equipment.

C: John Veccio  
P: +61 2 6925 6997  
E: john@bettersight.com.au

**ASSOCIATE OPHTHALMOLOGISTS**  
**PORT MACQUARIE**

An opportunity exists in Port Macquarie NSW, a rapidly growing regional hub, for an ophthalmologist to join our well-established practice on a full-time or part-time basis. Arrangements are flexible and include operating rights in the private sector at a purpose-built facility.

All sub-speciality interests welcome except glaucoma and vitreo-retinal.

C: Practice Manager  
P: +61 2 5527 8032  
E: lauren@pmec.net.au

**LOCUM PORT MACQUARIE NSW**

Five-week locum required from 3 July to 4 August 2017 in sunny and coastal Port Macquarie, NSW.

Expect a full patient load, purpose-built facilities, an experienced clinical support team and private operating lists in our onsite day facility.

C: Practice manager  
P: +61 2 5527 8032  
E: lauren@pmec.net.au

**LOCUM OPHTHALMOLOGIST REQUIRED**  
**REGIONAL VICTORIA**

A locum ophthalmologist is required to provide cover for a sole specialist practice in a regional coastal city in Victoria.

Locum dates are as follows:

- 30 June to 14 July 2017
- 4 September to 22 September 2017
- 30 October to 3 November 2017.

This specialist clinic is a fully equipped comprehensive practice providing all laser, OCT & angiography equipment, together with minor procedure facilities and is supported by clinical staff.

C: Jenny  
P: 0407 621 585

## Positions wanted

**SENIOR OPHTHALMOLOGIST AVAILABLE FOR LOCUM WORK**  
**AUSTRALIA/NEW ZEALAND**

Senior Adelaide-based ophthalmologist available for locum work anywhere in Australia and New Zealand.

C: Dr Alec Jordan  
P: +61 8 8267 2192

**CONSULTANT OPHTHALMOLOGY**  
**MD FRCSGlasg AUSTRALIA - ANY LOCATION**

Consultant ophthalmology MD FRCSGlasg searching for a job as an ophthalmologist.

C: Amr Ouda  
E: dramrouda@gmail.com